19 FEBRUARY 2000

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

LPCs push for change in their constitution

Pharmacies to be linked to NHS Direct by end of 2000

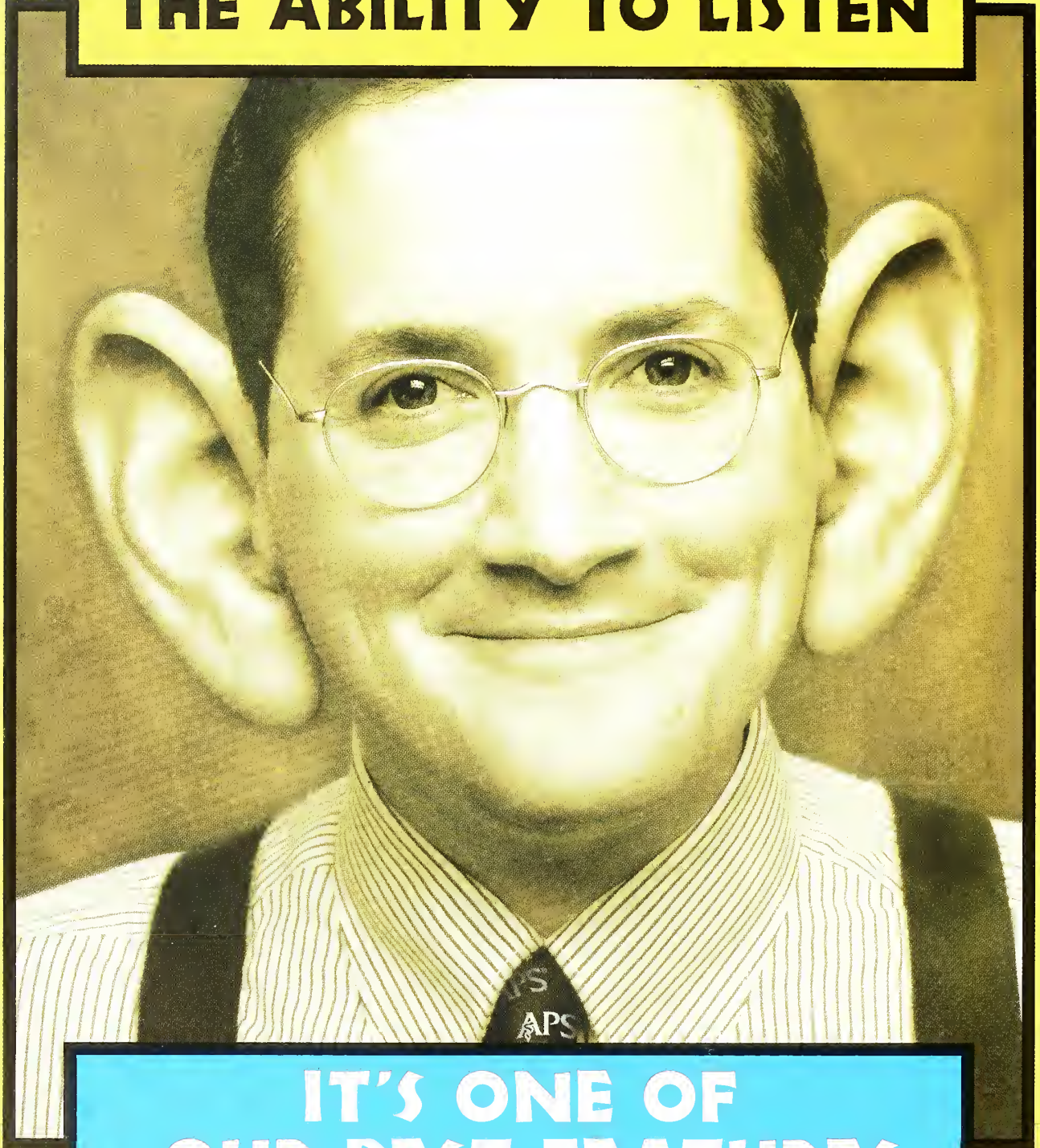
Clinical governance: what it means to you

New web site offers pharmacists up to 3,000 generics/PIs

Three year delay for business rate appeals

Update: *managing the pain in the pelvis*

THE ABILITY TO LISTEN



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THE NEWSWEEKLY FOR PHARMACY

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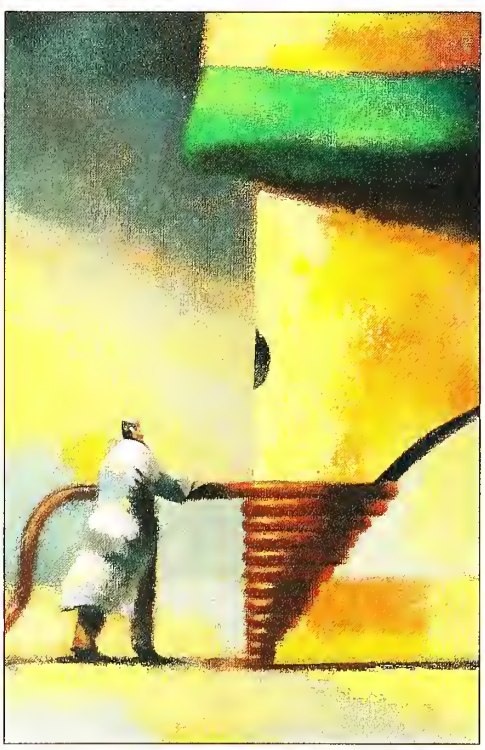
REGULARS

COMMENT

No LPC Conference would be complete without at least one resolution taking PSNC to task for 'lack of progress' and 'ineffective action'. All good stuff which allows for contractors' frustrations to be flagged up to our paymasters and helps keep the Committee on its toes. West Herts LPC has taken upon itself the throwing of the brickbats this year, but the serious business comes further down the agenda (p4). The balance of multiple and independent representation on LPCs has been out of kilter with current ownership patterns for some time. To its credit the Company Chemists' Association has not pushed for more seats at the LPC table, but the policy of 'wait and see' might be paying off. Two LPCs are seeking more flexibility in appointing or co-opting pharmacists to their committees. One says that the LPC constitution does not reflect changes in pharmacy ownership: the other says it cannot get enough independent contractors to sit around the table. With devolved NHS pay, primary care groups *et al*, the performance of LPCs is becoming ever more important to the wellbeing of local contractors. They need, therefore, to be effective and be filled with the 'right sort of people', who represent all local pharmacy contractors. Where they come from is arguably less important. A greater flexibility in appointing LPC members will inevitably mean more employees from the larger chains. But is this a bad thing? They can bring time and possibly the resources of a large organisation to the table without having to toe a party line. Changing the official model constitution to reflect the balance of businesses in the High Street will have a different result. There is a fundamental difference between these motions. The last thing LPCs want to end up with is fractionated voting based on the numbers around the table.



Editor Patrick Grice, *MRPharmS*
Assistant Editor Maria Murray, *MRPharmS*
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Beauty Editor Sarah Thackray
Reporter Steven Bremet *MRPharmS*
Art Editor Tony Lamb
Production Editor Vanessa Townsend, BA
Editorial secretary Jan Powis
Editorial (tel): 01732 377487; (fax): 01732 367065
E-mail: chemdrug@unmf.com
Price List
Colin Simpson *(Controller)*
Darren Larkin, Maria Locke
Price List (tel): 01732 377407; (fax): 01732 377559
Group Advertisement Manager
Julian de Bruxelles
Group Advertisement Executives
Simon Goddard, Christian Harris
Classified Executive
Debra Thackeray
Advertisement department secretary
Elaine Steele
Advertising (tel): 01732 377621; (fax): 01732 377179
Production
Karen Way
Associate Publisher
John Skelton *FRPharmS*
Group Sales Director
Ian Gerrard

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PPA ABC

Moss teams up with patient group

Moss Pharmacy has announced a three-year partnership with the Patients' Association.

Moss will act as an adviser to the Association on the role of community pharmacists in supporting patients' welfare and both organisations will be working together to develop more patient-friendly services.

Barry Andrews, managing director of Moss Pharmacy, said: "We are both customer- and patient-focused organisations who believe more must be made of the skills of pharmacists in the NHS. We intend to be actively involved in the drive to ensure patients make the best use of healthcare services."

Claire Rayner, president of the Patients' Association with Barry Andrews, managing director of Moss Pharmacy

Greater LPC flexibility?

A shake-up of the model constitution, which has been used for years by local pharmaceutical committees, could be on the way if resolutions at this year's LPC Conference on March 20 are supported.

Wakefield LPC wants to amend the constitution "to allow for more flexibility in the appointment of pharmacists willing to serve on LPCs". The constitution is "no longer robust enough ... and needs to reflect the changes in ownership patterns and functions of LPCs".

North & Mid Hampshire LPC is taking a slightly different approach and seeking changes which would "permit greater flexibility for co-option measures where LPCs have been unable to fill casual vacancies from the appropriate constitutional category".

The LPC says it has difficulty finding sufficient independent contractors to serve on the LPC. It realises, however, that there are considerable implications in changing the LPC constitution.

Most LPCs have 15 members made up of nine independent contractors, two Company Chemist Association (CCA) nominees, one Co-op nominee and three employee pharmacists (there is a nine member alternative used by smaller LPCs).

With the current profile of pharmacy businesses, multiples are under-represented on LPCs, which are playing an increasingly pivotal role at local level. However, PSNC secretary Steve Axon says there has been no pressure from the CCA for change.

Another motion from North & Mid Hampshire urges PSNC to amend the LPC constitution to take account of the development of primary care groups and trusts. These new groups could have an influence on negotiations for non-core elements of remuneration.

The LPC is concerned over the actions of "individuals and groups purporting to represent community pharmacy". LPCs should be recognised as the statutory consultative body in local negotiations, "so avoiding the potentially divisive nature of factions negotiating separate deals on behalf of independents of multiples ... This may involve a wholesale review of contractor interests and how these should be best represented to reflect the profession as a whole".

A maximum of 16 resolutions are to be debated at this year's LPC conference on March 8, since eight have been accepted by the Pharmaceutical Services Negotiating Committee without the need for debate.

Motions for debate

- Barking & Havering LPC is calling for a boycott of the next discount inquiry unless the movement in generic prices since the last one is taken into account. This is despite the fact that contractors are required to co-operate in such inquiries under their terms of service.
- 'Prescription switching' continues to irritate LPCs. West Herts and Redbridge & Waltham Forest call for contractors to withdraw from the point of dispensing checking scheme in retaliation. PSNC points out this would put contractors in breach of their terms of service and mean a reduction in fee income of £0.025 per script.
- West Herts LPC "regrets the lack of progress and indifferent outcomes resulting from ineffective action taken on resolutions passed by the conference recently, and calls on PSNC to demonstrate its respect for conference by the vigour and commitment with which it pursues conference objectives".

Resolutions accepted by PSNC

- **Gateshead & South Tyneside: PSNC should ensure that the oxygen budget is increosed realisticolly to reflect the actual increose ond incidence in consumption.**
- **Isle of Wight: PSNC should press the DoH to reinforce to health outhorities that odvice to residential homes should continue to be supplied through phormocy contractors.**
- **Leeds: PSNC should continue to press the DoH for the return of scripts to contractors for clorificotion where these have been tronsferred from the exempt to the non-exempt bundle, but where it is clear that the potient is exempt from script charges.**
- **Barnet: PSNC should vigorously pursue the concept of o flexible moximum per script not in excess of 28/30 doys.**
- **Wirrol ond Eost Herts: PSNC should negotiote new money for the provision of monitored dosage systems os an item of service poyment in the interest of potient sofety.**

PSNC seeks removal of clawback surcharge from April

The Pharmaceutical Services Negotiating Committee is asking the NHS Executive to remove, from April, the 1.06 per cent surcharge built into the clawback percentages set out in the *Drug Tariff*.

The £65.6 million liability for discount at November 30, 1998, is likely to be repaid by March. Despite the fact that copy invoice reports for 1997 and 1998 are still outstanding, PSNC decided at this month's meeting that contractors should not be penalised further.

"The sooner we can take the extra load off contractors to ease their cash flow, the better," said PSNC chairman, Wally Dove, at a press briefing on Monday.

The NHSE is proposing discount and container inquiries in April and further details are expected to be available for PSNC's March meeting. As there was no discount inquiry last April, it "came as no great surprise" that the NHSE was keen to have one this year, Mr Dove said.

There has been no response yet to PSNC's pay claim.

Rural dispensing As talks continue on possible changes to the rural dispensing regulations, relationships between PSNC and the GP Committee are still good, said Mr Dove. The NHSE had raised questions on the proposed package of changes and PSNC is soon to meet the GPC to discuss a joint response.

PCT powers A PSNC working group has been looking at the potential powers of primary care trusts, in particular the ownership of pharmacies and control of property. PSNC has been asked to comment to the NHSE on draft regulations and will issue guidance to local pharmaceutical committees.

The former health minister, John Denham, gave his assurance that PCTs would not be able to open pharmacies and PSNC will seek the same assurances from Lord Hunt.

Consortia pharmacies PSNC is soon to publish guidance on the legality and practicality of consortia pharmacies. Mr Dove said the guidance recognises there is a place for the one-stop shop but this should not be the model for the whole of pharmacy.

Algorithms for OTC prescribing The Royal Pharmaceutical Society has suggested that algorithms could be used to support pharmacists giving OTC advice, but PSNC believes this would be inappropriate for face-to-face consultation. Although computerised clinical decision support systems are used by NHS Direct, PSNC says patients are best served by pharmacists using their expertise to deal with each individual, rather than using a checklist approach.

Wasted medicines Following BBC 1's 'Watchdog Healthcheck' survey highlighting medicines wastage (*C&D* last week, p6), PSNC has written to Lord Hunt asking for a meeting to discuss 28-day maximum prescribing.

Pharmacy research PSNC is carefully evaluating the research proposed by the Community Pharmacy Research Consortium Steering Group, set up by the Society, before deciding on allocation of further funds.

Medicines management pilots An advertisement in the *Official Journal of the European Community* has resulted in 14 requests from universities and other institutions for more information on how they might be involved in the medicines management pilots. As *C&D* went to press there had been no official response to PSNC's £1.8 million bid for funding (*C&D* February 5, p7).

Tribunal needed for some matters, says Kirit Patel

The NPA's Kirit Patel

There is a need for a tribunal with discretionary power such as putting pharmacists on probation instead of making them appear before the Statutory Committee, according to Kirit Patel, National Pharmaceutical Association chairman.

Addressing the Asian Pharmacists Association in Manchester last week, Mr Patel criticised the lack of leeway when punishing pharmacists. "Currently it is an all or nothing approach. In your judiciary we have the High Courts as well as Magistrates Courts, and yet we only have one Statutory Committee to judge us." This was partly to blame for inconsistent sentencing, he said. A Statutory Committee case often also leaves the pharmacist with expensive legal fees.

Mr Patel was responding to remarks made by the Committee's retiring chairman, Gary Flather, that 70 per cent of those appearing before the Committee are of Asian origin. This is not due to racism within the Royal Pharmaceutical Society, said Mr Patel, but he acknowledged that there is a problem. He called for a working group to be set up to address the problem, working with the Society in a "positive manner".

Mr Patel also identified opportunities and threats facing the profession. Pharmacists must be more involved in primary care groups and primary care trusts, and show the Government that they can help deliver cost-effective healthcare, he said. Threats identified were competition from supermarkets, possible abolition of resale price maintenance and the power given to PCTs.

E-pharmacy is acceptable, he said, but only if there is supervision and delivery by local pharmacists. Internet sales of Pharmacy-only medicines may lead to a loss of pharmacist supervision and even the disappearance of the 'P' category.

- A spokesman for the Society confirmed that its Health Act Working Party is currently looking at all areas of professional regulation. There is no completion date available for the review.

Call for integrated pharmacy

The Government wants pharmacy to be integrated with NHS Direct and walk-in centres, according to guidance issued to the NHS and local authorities.

A list of 'must-do's' to modernise primary care includes completing the roll-out of NHS Direct by the end of 2000 and to "ensure that opportunities are taken to integrate NHS Direct and walk-in centres with modernised primary care services, including pharmacy".

'National Priorities: Guidance on Modernising Health & Social Services' over the next two years explains how to meet government targets for "fast, fair, convenient services".

Also mentioned under modern primary care is the need to develop the capacity of primary and secondary care to collaborate in commissioning services, and ensure full co-operation with regional specialised commissioning groups.

Other priority areas include smoking, drug abuse and teenage pregnancy. These three areas are to be priorities for local action via health improvement programmes.

There must be a range of specialist smoking cessation services provided to at least 150,000 smokers nationally, leading to at least 20,000 quitting on a long-term basis by March 2001. Tobacco use should be reduced nationally by at least one percentage point by next March. This could be achieved through local activity, particularly targeted at disadvantaged adults, pregnant women, and young people, supporting the National Education Campaign, and through smoking policies at all NHS and local authority premises.

Drug misuse services must be developed so that 15 per cent more problem drug misusers per health authority are accessing drug treatment services by March 2001. Health authorities must provide targeted prevention activity for at least 30 per cent of young people most vulnerable to drug misuse, and contribute to the national target of reducing Class A drug use among 11-16-year-olds by 20 per cent by 2002 and among under-25s by a quarter by 2005.

February Category D changes

The Pharmaceutical Services Negotiating Committee has issued this list of Category D items not included in the February *Drug Tariff*.

Chlorpromazine tablets 50mg, 500s; dothiepin capsules 25mg, 28s and 100s; ibuprofen tabs 600mg, 100; indapamide tabs 2.5mg, 28s and 56s; liquid paraffin & magnesium hydroxide oral emulsion, 2l; metoporolol tabs 50mg, 28s, 56s, and 100s.

Oxazepam tabs 15mg, 100s; phenobarbitone tabs 30mg, 28s; potassium tablets effervescent, 100s; prazosin tabs 500mcg and 1mg, 56s; quinine sulphate tabs 300mg, 500s.

PIANA roadshow dates announced

The Royal Pharmaceutical Society has announced the schedule for the first 'Pharmacy in a New Age' roadshows of this year.

The first three shows will take place in March at the following locations:

- Monday March 27: Stadium of Light, Sunderland
- Tuesday March 28: Royal Armouries, Armouries Drive, Leeds
- Wednesday March 29: Oulton Park Circuit, Jackie Stewart Business Centre, Little Budworth, Cheshire.

Pharmacists in the regions concerned will be receiving more detailed information about venues and times in the next two weeks.

SPGC announces drug shortages

Scottish Pharmaceutical General Council has issued the following list of drugs in short supply, for which PPD will accept pharmacists' endorsements for February:

Aluminium hydroxide tablets 500mg; chlorpheniramine tabs 4mg; chlorpromazine tabs 50mg; co-amilozide tabs 2.5/25mg; co-trimoxazole tabs 160/800; imipramine tabs 25mg; indomethacin capsules 25mg; mebeverine tabs 135mg; metformin tabs 500mg; minocycline tabs 50mg; trifluoperazine tabs 5mg.

Further information and updates will be posted on the SPGC web site, *www.spgc.org.uk*, the NPA site, or *C&D*'s dotpharmacy site.

Pharmacy plans on hold in NI

The suspension of the power-sharing executive in Northern Ireland leaves pharmacists wondering where they stand in taking forward healthcare plans.

Terry Hannawin, secretary, Pharmaceutical Contractors' Committee, told *C&D*: "We are very disappointed and saddened because the new administration seemed to be working well. We were looking forward to working with the new health minister and members of the Health Committee. We felt that local people would have a better grasp of local problems and local needs. We're keeping our fingers crossed that they will be back in post as soon as possible."

Joe Gault, the PSNI's acting secretary, said: "Everything is very fluid at the moment. The pharmacy bodies had started lobbying the new assembly, so that is now on hold."

More news on revamped dotpharmacy

DotPharmacy, the *Chemist & Druggist* internet site, is being given a fresh new look this week.

The opening page now gives greater prominence to the weekly news content and the more frequently updated 'stop press' section.

The layout now makes it easier to link straight to the news content.

The remaining site structure remains the same, says webmaster Geoff Le Prevost, but the pages have been redesigned in pharmacy green.

A number of new pages have been added, including a frequently asked questions section. The new-look site went on-line on Thursday.

www.dotpharmacy.com

NI survey on pharmacy use starts March

A survey into the use of pharmacies in Northern Ireland will start next month.

Customers entering 110-120 pharmacies will be counted and a sample asked general questions about why they are going to the pharmacy - to buy healthcare products, to ask for advice or to get a prescription dispensed.

The Department of Health has commissioned the survey, which will be carried out by PriceWaterhouseCoopers. The Department's Vanessa Chambers told *C&D*: "We know pharmacies are used a lot but we want to quantify that usage."

A representative sample of pharmacies has been identified and letters have been sent asking if they will take part. The patient questionnaires have yet to be finalised.

Other matters discussed at the January meeting of the Pharmaceutical Society of Northern Ireland's Council include:

NICPPET funding A single commission will be submitted, covering both the pre-registration year and continuing professional development. The first year of the three-year project will review and update the structure and content of the pre-registration year. The PSNI secretary, Joe Gault, will write to NICPPET about areas of concern for the year 2000-2001.

Pharmacy standards Dr Chambers will make a presentation to the next Practice Committee meeting, on developing standards in pharmacy. It was stressed that PSNI was responsible for setting the standards but will work with Dr Chambers in reviewing current standards.

Progress on web site The Practice Committee outlined progress on the good practice guide for installing the internet into pharmacy computers. There is concern over the number of providers seeking pharmacy involvement, and the aim is to introduce safeguards against viruses and loss of medication records. PSNI is also developing its own web page and a further report is expected soon.

Public relations The Council is seeking a more structured approach to public relations, with each of the main pharmacy organisations appointing a media spokesperson to act as first contact. In this way, a hospital pharmacist would answer queries about hospital pharmacy and a member of the Pharmaceutical Contractors' Committee would deal with remuneration.

Envelope stamp A new stamp for the society's franking machine carries the words 'PSNI 75th anniversary: Caring today for tomorrow's health'.

Pharmacy keeps flu vaccine supply

Pharmacists in Northern Ireland will continue to supply flu vaccines to doctors, but will receive less money.

In May last year the NI Department of Health wanted to change to a tendering process, but the Pharmaceutical Contractors' Committee objected because pharmacists had already started ordering stocks for the coming winter.

PCC secretary Terry Hannawin said: "We produced a package of proposals and eventually persuaded the Department that supply through pharmacies - which offers flexibility to the general public and continuity of the cold chain - was better than going out to tender." Pharmacists also had the support of manufacturers who felt the existing system worked well.

The Department has now given its written assurance that supply through pharmacies will continue. But, in return, pharmacists will have to accept a reduced price for the vaccine as the Department is keen to cut the cost of the vaccination programme. The dispensing fee will remain the same but the Central Services Agency will impose a discount on the manufacturer's price when the prescriptions are reimbursed. Mr Hannawin hopes the scheme will continue for at least three years.

Superdrug to expand flu vaccination scheme

Superdrug plans to expand a flu vaccination scheme that was trialed in nine of its pharmacies between October and November.

Vaccinations, which cost £10 each, were available by appointment on most weekdays. They were administered by a nurse in the pharmacy consulting room under a group protocol. Patients' GPs were informed and a vaccination certificate issued. A mobile vaccination service was also offered to local businesses.

"The service was extremely well received by customers, and we are keen to repeat the initiative and hopefully extend it to a wider number of stores this year," said Barry Simner, Superdrug's pharmacy general manager.

Boots is currently evaluating this winter's flu vaccination scheme. The company is intending to run a similar scheme next winter although details have not been finalised.

Pharmacist gives advice on air

A pharmacist has a regular slot on BBC Radio Solent talking about over-the-counter medicines and promoting the role of the community pharmacist.

Paul Rutter, a Moss Pharmacy research practitioner at the University of Portsmouth, has a weekly ten-minute slot in which he covers subjects from travel sickness to mouth washes. He has given generic pharmaceutical advice on eight shows and a further 15 are planned.

The pre-recorded interviews have been "well received" and there is the possibility they may be adapted to a live phone-in format. BBC Radio Solent claims to have one of the largest catchment audiences of all local BBC Radio stations. The Nick Girdler show, on which Mr Rutter appears at mid-morning on Wednesdays, has an audience of 25,000-50,000.

Pharmacists monitor quitters weekly

A smoking cessation scheme in Slough involves nine pharmacies, who give free NRT and follow up patients on a weekly basis.

Patients in the scheme, which is organised by Slough Primary Care Group, are referred to a participating pharmacy by a GP or practice nurse from one of the ten participating practices. Patients are given their first week's supply of NRT free of charge, and they only pay half the cost of their second week's supply. The pharmacist monitors quitters' progress each week either when they collect their NRT supplies, or with a telephone call.

Pharmacists are paid £50 for each client enrolled on the scheme. The PCG reimburses the cost of one and a half week's supply of NRT. Participating pharmacists had to attend a training course together with practice nurses.

The scheme will run for six months, but for the first two it is only open to smokers with associated cardiovascular risk factors.

Pharmacists on Welsh Task Force

Pharmacists will be appointed to subgroups of the Emergency Pressures Task Force, which was set up to review winter pressures on the NHS in Wales.

The decision to set up the subgroups was taken at the Task Force's first meeting last week. There are plans to involve pharmacists in these subgroups, although details have not been finalised.

Chaired by Jane Hutt, health and social services secretary at the National Assembly for Wales, the Task Force includes representatives from all key organisations in the NHS and local government. It will review the causes of pressures experienced over the winter and the response of the NHS and other related organisations, and identify examples of good practice within Wales and elsewhere.

Jane Hutt said: "This Task Force is aiming to produce an initial report by the summer recommending both short- and medium-term responses by the NHS and local government which promote operational practice in all sectors, and provide a framework for medium-term investment and planning. We will also be looking to promote more effective joint working between all the partners involved."

Food Standards Agency progress

Draft regulations paving the way for the Food Standards Agency to be set up on April 1 have been issued for consultation.

The Food Standards Act 1999 transfers responsibility for food safety and standards to the Agency and health ministers. The latest draft regulations complete that hand-over by amending secondary legislation to take account of the Agency's new responsibilities.

INDUSTRY VIEWPOINT

No hostages taken on the retail front

Over the last weekend, one of the main stories in the financial press was about the moves being made by the bankers to the Arcadia Group to remove its high profile chief executive, John Hoerner. He is being held responsible for the dramatic fall in Arcadia's share price over the past six months, and the current low level of trading in many of Arcadia's retail chains, which include familiar names such as Dorothy Perkins, Evans, Richards, Wallis and Burtons Menswear.

He is not alone in facing the wrath of discontented shareholders. Other chief executives who have fallen from grace in the past few months include Safeway's Colin Smith and Sainsbury's Dino Adriano. Yet just two years ago, these men were managing robust and highly profitable businesses.

"Despite the shock waves, the pharmacy sector remains surprisingly resilient"

They have all become victim to the most competitive retail market place ever seen in the UK. While Wal-Mart's acquisition of Asda has led to the aggressive round of price cutting in the grocery trade, the problems in the fashion sector have been more subtle - value conscious shoppers seeking low prices and only committing their money when they find them!

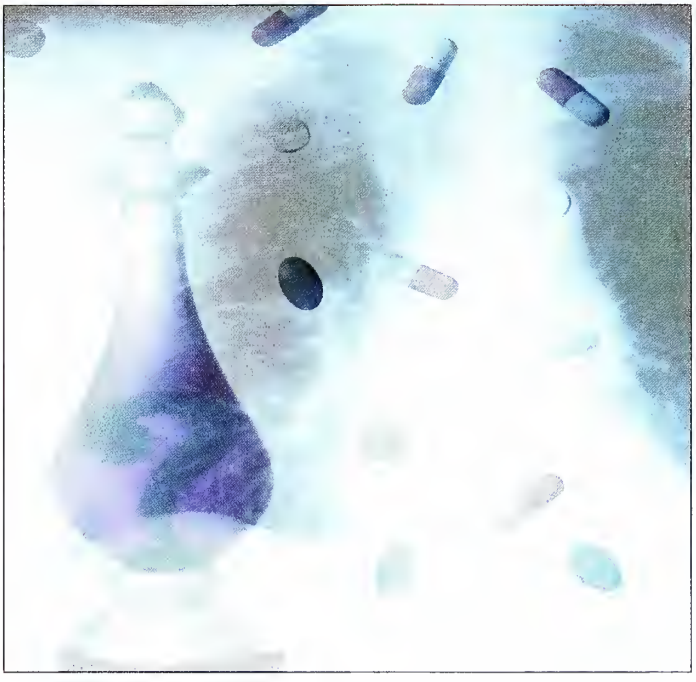
Despite the trading shock waves being felt by retailers such as Marks & Spencer, Somerfield and Sainsbury, the pharmacy sector remains surprisingly resilient. Most reports suggest that most pharmacists enjoyed reasonable sales over the important Christmas period. The flu epidemic in January certainly generated high sales of cough and cold medicines and a significant increase in NHS prescriptions. Perhaps the traditionally quiet months of February and March will reveal a bleaker trading environment?

The important fact to realise is that the retail market place is likely to become more competitive, and community pharmacists will need to exploit the unique combination of professional and retailing skills to ensure their regular customers perceive value in their local community pharmacy.

Written by a senior industry manager

Xrayser

Topical Reflections



Group protocols open up horizons for pharmacist 'prescribing'

In the same week that Schering Healthcare launched Levonelle-2, its progestogen only alternative for PC4, it also announced that it has submitted an application to switch the product from Prescription to Pharmacy sale.

There has been a lot of debate over the role of the community pharmacist in supplying the 'morning-after' pill. This has revolved not just around the moral issue, but also around the legality of the Manchester initiative where pharmacists have effectively prescribed the 'POM', PC4, by working within the framework of an agreed group protocol.

If Levonelle-2 is deregulated for Pharmacy sale, then many unwanted pregnancies would be so much more easily avoided. I look forward to playing my full part in its proper supply but I cannot see how the strict protocols that apply in the Manchester scheme can be applied to the sale of a P medicine.

But I am confident that, despite not having access to a private consultation room, I will be able to meet the confidentiality needs of a woman requesting Levonelle-2.

I currently alter my approach depending on the circumstances of the request. This may vary from talking in a quiet part of the shop to even using a corner of the dispensary, out of sight and earshot of the counter but not cut off by a closed door.

What is clear is that Levonelle-2 will break new ground if it is sold as a P medicine. The principles that will govern its supply could then be usefully applied to the deregulation of other Prescription Only Medicines.

Meanwhile the Manchester experiment will continue. Hopefully, it will establish a basis under which group protocols can be used to enable pharmacists to supply, on the NHS, a much broader range of treatments to patients who choose to visit their local pharmacy.

Pay prospects not helped by the prices paid for pharmacies

Another six substantial community pharmacies have been lost forever to the independent sector with the news of the latest Moss acquisitions since January 1 this year (*C&D* February 12, **Business News**).

I cannot criticise the owners, even high profile proprietors like Wally Dove, for selling because at an average price of almost £1 per £1 of turnover I, too, would be tempted by such an offer. Such sales, however, will not be seen as just another nail in the coffin of independent pharmacy, but a loud and clear message to Government that community pharmacy is still a highly profitable business!

I have little hope that reasoned argument for a reasonable pay settlement will be any more successful this year than in the past. But with news of these Moss purchases, and the presence of Phoenix serving to keep goodwill values high, out goes any hope of parity with other health professions or even the London Underground drivers!

However, the average proprietor pharmacist cannot hope to achieve a turnover approaching £1 million. If they could I would advise them to sell to Moss before the bubble bursts under the pressure of yet another imminent effective cut in remuneration.

The prices people will pay ...

During the past few weeks I have frequently been asked for the latest slimming miracle 'Bonsal'. The advertisement I was shown from a slimming magazine certainly promised much, but carefully avoided saying what was contained in the preparation or giving the price. However, it did recommend purchase from a pharmacy as well as the usual mail order alternative.

Since my wholesaler's telesales staff had never heard of 'Bonsal', I phoned the distributor, Nashi Pharmacy, to find out what made this product so special and to inquire about the price.

The young lady was very helpful. Chitosan was the miracle ingredient - and the price? A whopping £13.66 to sell at £19.99. Thanks, but no thanks!

At least I can now confidently tell my customers what 'Bonsal' contains and show them the alternative, my tried and tested Chitosan product, Fat Magnets. At £18.95 it has been a year-on-year best seller and on regular bonus I not only sell at a lower price to my customers but also make a nice healthy profit for myself.

NPA issues staff training guide

The National Pharmaceutical Association has produced a 'Guide to successfully training your staff'.

The distance learning package, available in four parts, is intended to help pharmacists identify the training needs of their support staff and to plan appropriate training for them. It should take about two hours to complete. The first section, 'How adults learn', is being issued to members with this month's supplement. The remaining sections will be circulated in March, April and May.

John D'Arcy, NPA director, said it was essential not to underestimate the importance of staff training: "At a time when quality is such a priority, and when as a profession we are fighting hard to prove our worth, we cannot afford to offer anything less than the highest standard of service."

Final call for life-long learning conference

A final call has been issued for papers for the Fourth International Life-long Learning in Pharmacy Conference, which is to be held on June 7-9, in Templepatrick, Northern Ireland.

The main feature of the conference will be a series of keynote lectures from internationally recognised authorities in life-long learning. There will also be workshops to develop skills, oral communications, posters on ongoing work, and a CPD fair where organisations can demonstrate the latest technology in action. It is hoped that 200 delegates will represent 30 countries. Delegates who register before March 31 will qualify for the preferential registration fee of £125.

Preloaded pens price cut to prevent blacklisting

Preloaded insulin pens will be reduced in price from March 1 in a move that has headed off a government proposal to have them blacklisted.

Announced at the same time as the decision to make pen needles prescribable (*C&D* February 12, p5), the move means that, from March 1, both re-usable and disposable pens will be reimbursed as well as pen needles. The Government's initial proposal was to make pen needles and re-usable pens available on prescription, but to blacklist the more expensive disposable pens.

"This rectifies a major anomaly in the availability of injection devices for people with diabetes," said diabetes expert Dr Roger Gadsby. "The cost of pen needles has prevented a proportion of patients from benefiting from the pen devices and I am delighted that a solution has finally been found to this problem without jeopardising the availability of the preloaded pens."

Novo Nordisk's preloaded pens containing Human Actrapid, Human Insulatard and Human Mixtards will be reduced in price from £26.33 to £24.40 for 5x3ml. NovoLet Novorapid will be reduced from £29.62 to £28.31. The company's vial formats have also been reduced in price to offset the new cost of durable pens. The price has been cut from £9.98 to £7.10 for 10ml.

Eli Lilly's Humaject pen will be reduced by 14 per cent to £22.68, and its Humalog Mix25 pen will be reduced by 5 per cent to £28.16. The company's Humapen will continue to be available free of charge from nurses.

NRT voucher scheme in NI

The first NRT voucher scheme in Northern Ireland has been launched in 26 general practices in the Eastern Health and Social Services Board area.

Patients attending health promotion clinics at these practices who are eligible for NRT will be given a voucher for a week's supply. Only patients exempt from prescription charges due to low income will be eligible for the scheme.

Which form of NRT is dispensed will be left to the professional judgement of individual pharmacist. Pharmacists will be paid £20 for each voucher dispensed. Anyone who was unable to attend the training sessions can obtain the Smoking Cessation Manual from NICPPET on 028 9027 2005.

NPA launches anticoagulant clinic pack

The National Pharmaceutical Association has developed a resource pack to help pharmacists and local pharmaceutical committees develop community pharmacy anticoagulant clinics.

The pack, which is the latest step in the NPA's bid to promote anticoagulation services (*C&D* January 22, p5), comes in three parts. An introduction looks at how anticoagulation clinics in community pharmacy have evolved, while Section Two looks at how to set up your own clinic. The final section contains useful resources such as quality standards and a service specification.

Free copies of 'Providing oral anticoagulant monitoring services in community pharmacy' are available from the NPA's professional development department on 01727 858687 ext 217, 293 or 339.

Concerns over unlicensed head lice product

Concern has been voiced about the use of a popular unlicensed product for the treatment of head lice.

North West Lancashire Health Authority's pharmaceutical adviser, Malcolm Phillips, is concerned that no scientific evaluation has been carried out on Follicel, which has no product licence but is being marketed as a head lice treatment. The product has received positive press coverage in *The Daily Telegraph* and *The Daily Express*.

Mr Phillips was speaking at a head lice seminar in Preston, organised by the product's manufacturer, Marabou.

Marabou is setting up a web site at *www.liceadvice.org* to offer advice on head lice and its treatment.

Geoff Marginson (right), of Marabou Ltd, demonstrates how to recognise head lice using scaled-up models

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Novartis Consumer Health on 01403 323953

www.nicotinell.co.uk

Legal category: P

Medical matters

Asthma link to 'sterile' living

Lifestyles that minimise exposure to foodborne and orofaecal infections are to blame for the rise in atopy and allergic asthma in developed countries.

Infections in early childhood are thought to protect people against developing atopy, but the type of infections that contribute to this 'hygiene hypothesis' has been a mystery.

In the latest *BMJ*, Italian researchers have found that it is exposure to foodborne and orofaecal infections rather than to airborne viruses that were responsible for protecting against atopy and respiratory allergy such as allergic asthma.

A retrospective case-control study examined 240 atopic and 240 non-atopic individuals taken from a sample 1,659 male airforce cadets aged 17-24 years old. Serology tests were examined for orofaecal and foodborne infections (*Toxoplasma gondii, Helicobacter pylori*, hepatitis A) and foodborne infections (measles, mumps, rubella, chickenpox, cytomegavirus, and herpes simplex virus type 1). Skin sensitisation and IgE antibodies to relevant airborne allergies, total IgE concentration and diagnosis of allergic asthma or rhinitis were also examined.

Researchers found that *T gondii*, hepatitis A and *H pylori* infection was less prevalent in atopic men than non-atopic men. Also, allergic asthma was rare and allergic rhinitis infrequent among the men exposed to at least two orofaecal and foodborne infections. The same association was not evident for airborne viruses.

The authors say the study is the first to show that orofaecal and foodborne microbes are better than airborne viruses at conferring protection against atopy. The microbes do this indirectly by influencing the gut-associated lymphoid tissue, where microbial stimulation is required to develop immune responses against allergens.

More studies are needed to verify this and to investigate potential use in preventing atopy. And further research is needed in training the immune system to prevent allergy, say the authors.

Homocysteine a risk factor for CHD in Asian men

Plasma homocysteine has been confirmed by a new study as an independent risk factor for coronary heart disease in Indian men living in the UK. The study in the *The Lancet* also helps shed light on why UK-based Indian men are at greater risk of CHD compared to their European counterparts.

The authors measured fasting and post-methionine load homocysteine, vitamin B12 and folate concentrations and conventional CHD risk factors in 551 males with CHD (294 European, 257 Indian Asian) and 1,025 healthy male controls (507 European and 518 Indian Asian). Fasting homocysteine concentrations were 8 per cent higher in CHD cases for both ethnic groups compared to controls. Among controls, fasting homocysteine concentrations were 6 per cent higher in Indian Asians than in Europeans. The authors estimate that elevated homocysteine may contribute to twice as many CHD deaths in Indian Asians compared with Europeans. The difference in homocysteine levels between the two groups was attributed to lower vitamin B12 and folate levels in Asians.

The authors conclude that plasma homocysteine may be used as an independent risk factor for CHD in UK Indian Asians. Because the raised homocysteine levels are related to vitamin deficiency, the authors conclude that CHD risk may be reduced by dietary supplementation.

Lanolin bad press unjustified

A report by a consultant dermatologist argues that the bad press surrounding the allergenicity of lanolin is unjustified and outdated.

In his review of lanolin, Dr Andrew Wright of St Luke's Hospital in Bradford, says that the allergenicity of lanolin goes back to early studies in the 1950s when the poor industrial extraction processes failed to remove contaminants such as soap residues and pesticides. Later studies found that lanolin allergy in the general population was low, suggesting that the emollient was a very weak sensitiser.

For the few that are allergic to ordinary lanolin, Dr Wright suggests that purified lanolin - one that has had its free fatty alcohols reduced and detergents removed - may be the answer. Purified lanolin has been found to reduce the detectable rate of hypersensitivity by 96 per cent.

Wider acceptance of lanolin could allow more patients with eczema and other dry skin conditions to benefit. "Lanolin has received unjustifiably bad press that has helped to narrow patient choice of emollients. It is hoped that this report will meet the demand of GPs by clarifying the evidence, supporting lanolin's unique properties and establishing a wider emollient choice for patients." A recent survey found that a third of the 150 respondents from the Royal College of Nursing Dermatology Group felt that the presence of lanolin in emollients had limited their prescribing.

● 'Lanolin Review - an assessment of the clinical evidence supporting the efficacy and safety of lanolin' can be obtained from Hill & Knowlton, tel: 020 7413 3516.

Chocolate aroma boost to health

St Valentine's Day now comes with added health benefits. The aroma of chocolate can boost the immune system but only in men.

In a Science of Chocolate seminar held at the Royal Institution, Dr Angela Clow of the University of Westminster said the smell of chocolate increases the production of immunoglobulin A secreted in the saliva and helps protect against common infections such as colds. However, women who found the smell of chocolate more pleasant than men did, experienced no significant boosts in antibodies.

The aroma of chocolate also had a soothing and calming effect on the brain. Dr Neil Martin, a psychologist at Middlesex University, said they were now looking at ways of using chocolate and other calming odours to reduce people's experience of pain.

Chocolate contains phenylethylamine, a neurotransmitter found naturally in the brain, which also acts to raise dopamine levels in the body. This leads to a boost in blood pressure and heart rate and a heightening of sensation.

SCRIPT BRIEFS

Merbentyl sizes up

Florizel has introduced a new 120ml presentation of Merbentyl Syrup (dicyclomine HCl 10mg) to replace the current 500ml presentation. The new pack will be cartoned and will come with a PIL. The basic NHS price is £1.98. Merbentyl is distributed by:
Distriphar UK.
Tel: 01895 837776.

Indications for Oxycontin and Oxynorm (oxycodone)

OxyContin and OxyNorm (oxycodone) are indicated for the treatment of moderate and severe pain of malignancy and post-operative pain. Moderate pain was omitted from the indications carried in *C&D* Script Specials, February 5.
Napp Pharmaceuticals.
Tel: 01223 424444.

Lotronex approved in US

Glaxo Wellcome's new treatment for irritable bowel syndrome Lotronex (alosteron) has received marketing approval from the US Food and Drug Administration (FDA). The drug is expected to be available in the US by mid-March. Alosteron, 5-HT_3 antagonist, has been approved for use in female patients with irritable bowel syndrome whose main symptom is diarrhoea. The drug has also been submitted for approval in Europe.
Glaxo Wellcome plc.
Tel: 020 7493 4060.

More Understanding

Family Doctor Publications has introduced two new titles in the health information book series. 'Understanding Infertility' aims to explain more about getting pregnant and where things can go wrong. 'Understanding Food & Nutrition' explains nutrition and provides an overview of food labelling, additives, dietary supplements, food intolerance and 'alternative' diets. Each book is priced £2.49 and is available from:
Family Doctor Publications.
Tel: 01295 276627.

Update correction

The MCQ for Adverse Drug Reactions (modules 1151) carried in last week's *Chemist & Druggist* included an error. Question G should have read 'Identify which one of the following factors does not affect the predisposition to suffer from ADRs ...'.

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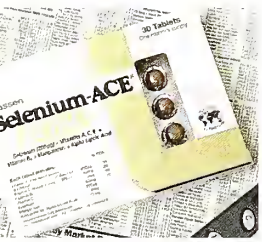
Happinose Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD1 7JJ, UK **Directions:** For adults, blow the nose before application. Carefully apply 1 cm of Happinose inside each nostril using the little finger and inhale. Re-apply every four hours or as required. For children 10 years and over, as above, but use up to ½ cm. For children between 5-9 years, as above, but use up to ¼ cm. **Indications:** For the symptomatic relief of nasal congestion associated with the common cold, catarrh, head colds and hayfever. **Contraindications:** Do not use on children under the age of 5 years. Not to be used in cases of sensitivity to any of the ingredients. **Precautions:** FOR EXTERNAL USE ONLY. Keep away from the eyes. Keep out of the reach of children. Hands should be washed after use. **Legal category:** GSL **Packs:** Happinose (PL 0173/0177) - 14g. RSP £3.45 (£2.94 excluding VAT)

Counterpoints

Wassen adds to selenium supplements



Wassen International is launching a new selenium supplement with alpha lipoic acid.

Selenium-Ace Extra provides 200mcg of selenium combined with alpha lipoic acid, further antioxidants and B vitamins.

The company says the product has been launched in light of growing scientific evidence of the benefits of this amount of selenium.

Alpha lipoic acid is a new ingredient for Wassen products. It is a powerful, vitamin-like antioxidant, found in every cell in the body, which helps protect the body from free radicals.

Consumer promotions and a press advertising campaign will support the launch.

The supplement retails at £5.95 for 30 tablets. Trade price is £20.27 for six packs.

Wassen International Ltd.
Tel: 01372 379828.

Avent Soothers reach for the stars

Cannon Avent is launching a new range of soothers featuring designs such as moons, stars, teddies, frogs, queen bees and princesses.

Avent Soothers (rsp £2.59-£2.99 for two) are divided into three specific age groups - 0 to three months, three months plus and six months plus.

Each soother features a vented symmetrical orthodontic teat and a protective snap-on cap to promote hygiene.

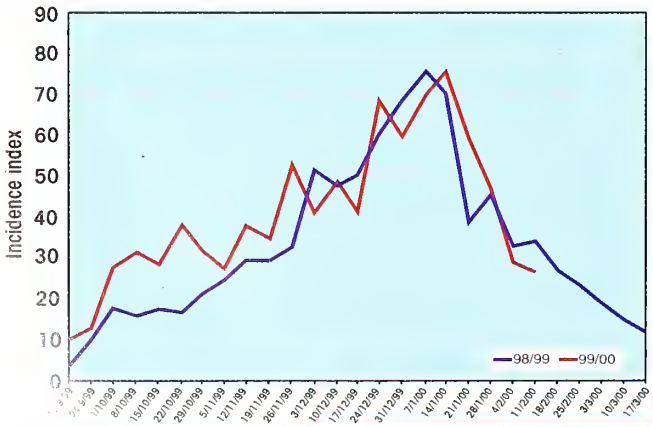
Cannon Avent.
Tel: 01787 267000.

Cough, cold & flu FORECAST

Information updated weekly by SDI

A further fall in the incidence of respiratory illness this week sees the UK move to Normal status after one week on Advisory. Manchester is the only centre to remain on Alert, for the tenth week in a row, with a severe risk of respiratory illness. Norwich remains on Advisory status with a moderate risk of illness. All other centres have returned to Normal. Birmingham, Bristol and Leeds have seen significant falls in the index and now have a low risk of respiratory illness.

For more information on the cough cold and flu forecast contact your Warner-Lambert representative.



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MARKET STATUS
NORMAL

UniChem introduces better buys for baby

UniChem is adding new junior paracetamol sachets and four new baby toiletry products to its own-brand baby care range.

New strawberry flavoured Junior Paracetamol Suspension sachets are formulated for the relief of pain and fever.

Each single dose sachet contains 120mg of paracetamol. Designed for convenience, the sachets can be carried around by parents.

Suitable for children from birth until three years, the product retails at £2.29 (ten sachets). Trade price is £6.53 for a case of six units.

The new value-for-money toiletry range comprises baby lotion, shampoo, bubble bath and baby oil. The products are packaged in brightly coloured ergonomically designed bottles.

Martyn Ward, UniChem's sales and marketing director, says: "We recognise the need to provide independent pharmacies with good quality, top value alternatives to the leading brands. This ensures that they are able to offer the same range of choice and value as is offered by multiples."

For an introductory period, UniChem is offering 20 per cent off the trade price, providing a profit on return of up to 42 per cent.

Free signage and display is available for pharmacies to encourage multiple purchase.

- UniChem plans to relaunch its feminine hygiene range with bolder packaging and higher quality products.

Plans are also underway for other own-brand additions including APS film, effervescent vitamin C tablets and a new herbal range to coincide with the increasing pharmacist interest in holistic treatments.

UniChem Ltd.
Tel: 020 8391 2323.

Compeed gets kids plastered

Coloplast is launching a new range of children's plasters in its Compeed range on April 1.

Compeed Kidz plasters are specifically designed to alleviate pain and pressure, as well as provide optimum healing conditions. They come in three fun designs - zebra, tiger and leopard prints.

Made from a smooth, slim elastic, the plasters have a hypo-allergenic adhesive that can be used by those who suffer from eczema and psoriasis. A semi-permeable polyurethane film protects against water, dirt and bacteria while still allowing the skin to breathe.

The plasters are designed to absorb and retain the skin's own moisture which prevents a scab forming over the wound. As no scab is formed, there is less visible scarring once the plaster is removed.

The launch will be supported by a national 'design a t-shirt' competition in a children's magazine, as well as consumer reader offers.

A plastic box containing six plasters will retail at £3.69.

- Coloplast is also launching new bunion plasters in the Compeed range on March 1 (rsp £3.69 for five).

Coloplast Ltd.
Tel: 01733 392000.

...must work round the clock.

Think cold relief, think Benylin Day & Night. Only Benylin Day & Night provides 24 hour cold relief by combining non-drowsy day-time tablets for on-the-go relief, with special night-time tablets that ease symptoms and so aid restful sleep. So for round-the-clock relief in a single pack, think Benylin Day & Night first.

Day: Paracetamol, Phenylpropanolamine
Night: Paracetamol, Diphenhydramine

Benylin

The name to think of first

Benylin Day and Night. Presentation: Blister pack containing fifteen amber film-coated tablets and five blue film-coated tablets in opaque blisters. Each amber daytime tablet contains: 500mg Paracetamol and 25mg Phenylpropanolamine hydrochloride. Each blue night-time tablet contains: 500mg Paracetamol and 25mg Diphenhydramine hydrochloride. **Uses**: Symptomatic relief of colds and influenza. **Dosage**: Adults and children over 12 years: 4 tablets should be taken daily - three amber tablets during the day and one blue tablet at night. Do not take the night-time tablets during the day. **Contra-indications and Precautions**: Known hypersensitivity. Caution in patients with hyperthyroidism, hypertension, cardiac dysfunction, diabetes mellitus and liver disorders. Not for use by patients who are taking, or who have taken, monoamine oxidase inhibitors within the preceding two weeks. Not to be used during pregnancy. Avoid alcohol. **Side and adverse effects**: May cause drowsiness, if affected do not drive or operate machinery. Paracetamol can cause skin rashes. Phenylpropanolamine may give rise to dizziness, headache, nausea, tremor, anxiety, insomnia and palpitations. **Price (ex-VAT)**: £3.14. **Legal category**: P. **Product licence holder**: Warner-Lambert Consumer Healthcare, Chestnut Avenue, Eastleigh, SO53 3ZQ. **Product licence number**: 15513/0045. **Date of preparation**: October 1999.

Clairol's crowning glory for over-stressed hair

Bristol-Myers is adding a new intensive conditioning product to its Clairol Daily Defense range.

Daily Defense Intensive Conditioning Masque is designed for the ever-increasing number of women with damaged, over-stressed hair.

The concentrated product is formulated to help restore lustre, shine and manageability to dry, damaged hair. It contains a nutrient complex to fortify, protect and renew the hair's natural resilience.

If used weekly as a hair treat, the product should be left on the hair for five minutes before rinsing for best results.

For dry, damaged, colour treated and permed hair, it can be used after every shampoo, rinsing out after one to three minutes.

Retail price is £3.89 for 200ml.

Bristol-Myers Co. Ltd.
Tel: 01895 628000.

Miners' launch stacks lipsticks high

Miners International will launch a novel multi-selection lip product in June.

Miners' Lipstack contains five miniature pots of Essential Lipstick, a petite lip brush and a mini mirror.

Each pot swings outwards, allowing the user to select a particular shade or to mix and blend shades to create an individual colour.

The product is available in three variants - Pinks, Browns and Party.

Retail price is £2.99.

Miners International Ltd.
Tel: 01264 325500.

Elizabeth Arden awakens your spirits with a splash of green tea

Elizabeth Arden is launching a fresh new fragrance and bodycare range based on green tea in the UK on March 6.

The Green Tea Fragrance and Bodycare range is already a success in the US, where it was launched last August.

Designed to be uplifting and energising, the collection will initially be launched with five products - eau de toilette spray, tub tea, refreshing body lotion, tub rub (an exfoliating scrub) and energising bath and shower gel.

Further products will be added to the range throughout this year. These will include a scented candle, aromatic scented pebbles, calming gel patches, rejuvenating foot polish and a foot lotion.

Retail prices range from £10 for the energising bath and shower gel to £23 for the 100ml scent spray.

● Elizabeth Arden will introduce its spring colour collection on April 2. 'Sheer Brights' is a palette of shades that create a radiant, fresh-looking face.

The collection includes two new cream-to-powder products. Cream-to-Powder Eyeshadow Duos (rsp £16.50) are smooth, silky eyeshadows in two combinations. Cream-to-Powder Cheek Colours (rsp £17) come in Pink Glaze for sun-kissed cheeks and Sunbeam - a highlighter to create an all-over, subtle glow.

Also new in the collection is Natural Volume Mascara (rsp £13). The product features a new mixing mechanism (contained within the tube) which is designed to keep the formula fresh and clump-free through multiple applications. The mixer revolves through the formula each time the tube is twisted open or closed. The mascara will be available in two shades - Black Ebony and Sable Brown.

Elizabeth Arden Ltd.
Tel: 020 7574 2700.

Alberto is going straight

Alberto-Culver is launching a new styling gel to help straighten curly and frizzy hair.

Advanced VO5 Straight Hair is applied to damp hair and is heat activated - the action of blow-drying facilitates the straightening effect.

The product has a light, non-greasy formulation enriched with botanical extracts and silk protein. It is formulated to leave the hair smooth, shiny and tangle-free.

The gel is available in two sizes: 150ml (rsp £3.99) and 30ml (£1.29).

Alberto-Culver Co UK Ltd.
Tel: 01256 705000.

Apricot milk adds shine to hair colour

Laboratoires Garnier is improving its Movida Conditioning Crème-Colorant with a new formulation for the after care conditioner.

The tone-on-tone colorant now includes a conditioner with a nutritive apricot milk extract.

It has a light apricot fragrance and is formulated to leave the hair soft, shiny and tangle-free after colouring.

New in the Movida pack are details of a local rate advice hotline for one-to-one expert advice on all aspects of haircare and colouring.

The tone-on-tone colorant retails at around £4.49 and is available in 17 shades.

Laboratoires Garnier.
Tel: 020 8762 4010.

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Going for gold with Duracell Ultra

Duracell is giving away trips to Sydney to see the Olympic Games in a new on-pack promotion for its Duracell Ultra battery brand.

On shelf from the end of March, the promotion invites people to take part in an Olympic style race. Each AA pack is marked with a lane and vest number.

A flat rate £0.25 interactive phone line invites participants to input these details and take part in a race on which they hear commentary.

Ten gold medallists will win trips to Sydney, with winners who claim their prizes by July 31 going to the Olympic Games. Silver medallists will win one of 500 Cannon cameras, with bronze medallists awarded one of 10,000 sports shirts.

The promotion runs until December 31.

Duracell (UK) Ltd.
Tel: 020 8560 1234.

Invigorating Radox campaign

Sara Lee is supporting its Radox Showerfresh brand with a £1.3 million TV advertising campaign from March 13 until April 9.

The commercial communicates dramatically the brand message that it can 'invigorate body and mind'.

The campaign focuses on the added benefit of invigoration and aims to encourage consumers to trade up from bar soap.

Sara Lee UK Ltd.
Tel: 01753 523971.

SB launches new attack with Beechams for Natural Defence

SmithKline Beecham is supporting its Beechams for Natural Defence with new promotional and sampling activity designed to encourage product trial and to drive sales.

SB has teamed the product with Lucozade to create 'energy packs' and 'rescue packs' for consumer giveaways in the national and regional press and local radio stations to maximise awareness nationwide.

Samples will also be offered to brides, who are primarily aged between 18 and 35 (identified as core users of food supplements), at the National Wedding Show in London this March.

Promotional activity includes the distribution of a glossy 20-page booklet entitled 'Healthy ideas for winter'.

Introduced by TV presenter Stacey Young, the booklet features energy boosting exercises, beauty tips, healthy food and walks. Reference copies are available to retailers (while stocks last) by calling the pharmacy helpline on 0500 888878.

SmithKline Beecham Consumer Healthcare.
Tel: 020 8560 5151.

Survey reveals public confusion about dietary supplements

There is widespread public confusion about the functions and correct dosages of vitamins and minerals, according to a Gallup survey commissioned by Saga – a specialist in goods and services for people over the age of 50.

Fewer than half of the respondents understand that the RDA on packaging means the recommended daily amount of the vitamin or mineral people should eat.

Thirty-one per cent believe it means the supplement alone gives the recommended daily amount and 9 per cent think that it represents the amount they should take over and above the supplement.

The survey shows that 59 per pent of adults now take dietary supplements. The most popular products are multivitamins, followed by cod liver oil and vitamin C, taken by 26 per cent, 24 per cent and 16 per cent respectively.

The survey was commissioned to coincide with Saga's launch of a new range of nutritional supplements designed specifically for the 50 plus age group. The range will only be available to the public through the internet and direct from Saga.

AAH backs baby sales in pharmacies

AAH Pharmaceuticals is strengthening its commitment to the babycare category in pharmacies.

The wholesaler has worked in conjunction with Johnson & Johnson and Nutricia to devise a new initiative for pharmacies.

The programme includes clear advice on best product lines, market trend analysis, merchandising visits, Vantage PoS material, marketing support and pharmacy assistant training in infant feeding.

The initiative takes into account market trends such as a move towards organic baby foods and focuses on leading products such as nappies.

As part of Vantage monthly promotions, members benefit from leaflet drops to 5,000 households in their catchment area.

Each leaflet includes a coupon for customers to enter a prize draw for one of ten Johnson & Johnson In-touch Reassurance Monitors.

A distance-learning course in infant nutrition will be introduced this year for pharmacy assistants.

AAH Pharmaceuticals Ltd.
Tel: 024 7643 2000.

ON TV NEXT WEEK

Aquafresh Active toothpaste: All areas
Aquafresh Flex tip toothbrush: All areas
Beechams: U
Canesten Once: G, Y, C, CAR, TT, C4
Clearblue Home Pregnancy Test: G, A, W
Gillette Mach3 razor: All areas
Imodium Plus: All areas except CTV
Movelat Relief: B, G, A, HTV, M
Niquitin CQ: All areas except U, CTV, C4
Nytol: All areas
Olbas: C5
Sabalin: CAR, C, M, C4, C5
Setlers: All areas

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

How does the OTC industry get its message across to decision makers and how does that benefit pharmacists? Gopa Mitra, head of public affairs at the Proprietary Association of Great Britain, explains how the PAGB supports self-care in the new NHS

Share and self-care

The OTC industry has achieved a strategic objective in making self-medication an item of Government policy. But the debate continues as how best to get the public to buy the idea, and how to control demand.

The Prime Minister and his policy advisers have made it clear that they are looking for novel solutions to come from the grass roots of the NHS. These solutions may come from health action zones, focus groups or research projects, which provide information on attitudes to health upon which new thinking can be based.

The Government's White Papers - 'The New NHS - Modern and Dependable' and 'Saving Lives' - have placed self-care at the centre of policies designed to make people more self-sufficient in terms of their own healthcare.

The PAGB's own research shows the public is broadly in tune with Government policy. Our data shows that not only are consumers willing to self-medicate, but that this can lead to savings both financially and in GPs' time.

Four out of five people believe it is important to have medicines they can buy to help relieve minor ailments[1], yet is has been estimated that 39 per cent of a GP's time with patients is taken up with these minor ills[2]. If just one quarter of these consultations could be avoided there would be 24 million fewer GP consultations every year, resulting in savings to the NHS of £380 million.

However, getting self-medication on the political agenda has been a lengthy process. Over the past decade, the PAGB has worked to persuade policy makers that increased self-care is the way forward.

Working with other like-minded groups has provided an important focus. PAGB has an established consultative role with representatives on the Doctor Patient Partnership Board, and the Royal Pharmaceutical Society's working group on self-medication and the pharmacist.

Last year, the PAGB ran a conference jointly with the NHS examining the impact of the new NHS strategy on self-care and self-medication. Among the issues were whether health information technology would demystify medical care, and how structural changes in the NHS would impact on individuals.

Demand management was the focus of a debate held at the House of Commons, hosted by Lord Toby Harris and sponsored by the PAGB, last November. NHS Direct, walk-in centres and publicity campaigns encouraging consumers to consult their pharmacist are ways of controlling the demands made on GPs.

This year, for the first time, the NHS winter campaign told consumers that antibiotics would not work for colds and flu. A recommendation pad advised patients about self-care options for colds and coughs, and the treatments available from the pharmacy. This is a significant step, putting pharmacists alongside GPs in the care of common ailments.

The appropriate use of self-care will be key to managing demand on the NHS. This approach also highlights the need to integrate healthcare services and the availability of information if patients are to be encouraged to responsibly self-medicate.

The plan for 2000

How will the PAGB keep self-care high on the political agenda during 2000? It will continue to build on common ground by developing a programme of third party activity. Our parliamentary contact programme and links with the DPP will be developed.

In June there will be a joint conference with the DPP, NHS Direct and the National Pharmaceutical Association. It will look at what is, in effect, a counter-revolution in self-care. Self-care used to be the first line of treatment and today we are returning to that view but within an integrated system.

To support this activity we need to be sure of the facts. The PAGB is funding three research projects:

- Chester GP, Dr Timothy Hammond, will explore 'Patients' use of the community pharmacist' and assess patients' use of community pharmacists before seeing a GP, and the outcome of patients' consultations with community pharmacists
- 'Self-care and healthcare-seeking behaviour for headache and its relationship to headache experiences and medication use' is a project headed by Helen Boardman, a pharmacist at Keele University. It will investigate healthcare utilisation and perceptions of headache in the primary care population
- Sharon Conroy, a pharmacist at the University of Nottingham, is leading the third project, 'The use of OTC medication in children in the East Midlands'. It will look at why parents buy OTCs for their children and how they are handled in the home.

The Government is addressing the issue of demand management, of which self-care is an essential element. All the work being done by NICE, Prodigy and PCGs will increase pressure on GPs to re-examine their prescribing habits.

Inevitably this will mean a greater focus on self-care. NHS Direct, the NHS Health Care Guide and NHS Direct Online are all indications of government encouragement for people to look after themselves at home when it is appropriate.

The PAGB will also respond to treatment recommendations handed down by NICE. The brief of NICE is to assess new technologies and the cost-effectiveness of treatments.

NICE is also starting work on its clinical guidelines programme. This will cover all aspects of clinical care, from self-care through to primary and secondary care. Referral protocols will help GPs and patients decide when a consultation with a specialist is necessary. There is a potential impact on self-care, and we will aim to ensure that any decisions are grounded in the wealth of research we have available.

Self-medication saves NHS resources and offers people a fast and convenient way of dealing with the symptoms of minor illness. It's essentially a simple message that industry and community pharmacists should be promoting together.

1. BMRB Everyday Healthcare Study 1997
2. PMSI poll, commissioned by the PAGB, 1997

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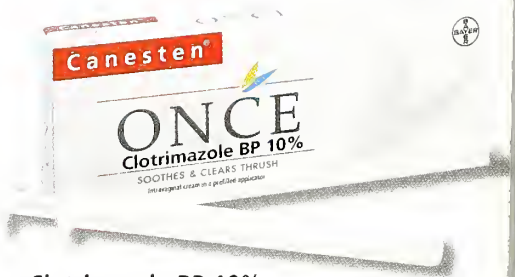

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PHARMACYupdate

Ending the suffering

Endometriosis is a complex and painful disease affecting around 1.5 million women in the UK. Angela Barnard, chief executive of the National Endometriosis Society, outlines how the disease is managed

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1154), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* MARCH 11, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To recognise the presentation of endometriosis
- To be aware of the possible causes of the disease
- To recognise the problems of diagnosis
- To understand how the disease is managed
- To be aware of the personal impact of the disease

Endometriosis is a complex disease that challenges researchers, clinicians and, most of all, the growing number of women being diagnosed. While there are convincing theories about its cause, there is still no certainty and a cure has yet to be discovered. In addition, the disease boasts a complexity, probably unique in gynaecology.

Description

Endometriosis is a condition in which cells of the endometrium become established outside the uterus but continue to respond to the cyclical hormonal stimuli of the pre-menopausal woman. As oestrogen increases, these cells proliferate and then, in the presence of increased progesterone, they break down. Unlike the lining of the uterus, these cells of endometrium cannot escape during menstruation. Instead, they spread over and between organs, creating scar-like tissue and forming cysts. This mainly occurs within the confines of the peritoneum, but it can be found in the lungs, diaphragm and other remote sites.

Within the pelvis, endometriosis has three basic manifestations. The first are deposits of tissue, most commonly found on the surface of the peritoneum, reproductive and other organs. The second are adhesions, which join organs to one another and/or to the peritoneum, and endometriomas, which usually occur on the ovaries. These are often referred to as 'chocolate cysts', being filled with dark, viscous blood. The third manifestation is not readily seen because the endometrial tissue becomes embedded but it can often be identified as nodules on the recto-vaginal septum.during manual examination. A woman may have one, two or all of these forms of the disease.

Incidence

As the gold standard diagnostic tool is visual recognition via a laparoscopy, most of the mechanisms for establishing incidence are not available. Studies have suggested the figure to be anything between 1 and 15 per cent of women, or 150,000 and 2.2 million. However, the most frequent finding has been around 10 per cent or 1.5 million. While diagnosis is typically in the early or mid-30s, this by no means establishes a prevalent age group. The disease can affect any woman between menarche and menopause. The typical presentations of endometriosis are pain and/or problems achieving conception.

Causes

It is almost universally accepted that menses pass up through the Fallopian tubes into the pelvic cavity, as well as passing through the vagina. Evidence of this is suggested by the presence of blood in the peritoneal fluid around the time of menstruation. Although this is a common finding, an alternative explanation is that the blood in question is produced as ova are released from the ovary.

However strongly held, this theory does not explain why the disease occurs in some women and not others. Hence, there is another theory that the disease is

Continued on PII →

Continued from P1

due to an immune dysfunction. Exponents of this theary aften cite o suspected relationship between the proliferation af endometriasis and high levels of environmental toxins. Same go further and include the presence af high oestrogen foods, such as saya, as environmental factars, quoting the high incidence of endometriasis found in Japan.

A further theory cites the seven-fold increase in occurrence among women having a close female relative with endometriosis. However, this may be due to a greater awareness among this group compared with a law level of awareness among the female population as a whale. It is reasonable to suggest that such women are more likely to achieve a diagnosis, and more quickly, than their counterparts who anly hear af the disease on diagnosis.

Finally, another theory suggests that migrant cells from the developing uterus af the faetus are the cause, thus explaining an apparent pre-disposition ta the disease. In the face af all af these, many cansider it likely that there is no single cause, but a set of factors, the presence of some or all of which is likely ta give rise to endometriosis.

Diagnosis problems

Far the clinician, diagnasis is challenging. The absence of either an established pre-dispositian ar a non-invasive test are not the only problems faced in diagnosis. It is also the case that the extent of the disease does not necessarily relate to symptams. It is passible for a woman to experience debilitating pain with only minimal disease or to experience no symptams, despite having extensive disease. In addition, the presence of other symptams can be distracting. These range from menorrhagia, pain an bowel mavement, pain during intercourse (dyspareunia), bladder pain, lawer back pain and fatigue. Endometriosis is also discavered among women with na symptoms, but who experience difficulty conceiving.

One survey, carried aut in the UK six years ago, found that a high praportian of wamen had first been diagnosed with irritable bowel syndrome, which was only reviewed when there was na response ta treatment. An alarmingly high praportion had also been diagnosed with appendicitis ond surgery ensued. The appendix con be affected by endometriosis but, unfortunately, the survey did not reveal whether this wos estoblished ot post surgicol biopsy.

More difficult still is the prevolent occurrence of pain during menstruotion, some of which does not readily respond to OTC analgesics. Not all such pain can be explained, even after laparoscapy.

Sa the clinician must balance passibility and prabability befare referring a waman far diagnastic pracedure. While laparoscopy is classed as 'minar surgery', it is important ta acknowledge that there is no such thing as surgery without risk.

Finally, endametriasis is a disease that has not featured praminently in medical training, and general medical texts either do not include it or give slight reference to it. More assistance in identifying symptoms is needed for those in primary care, if women are to receive timely diagnosis. In the above survey, the average delay between first reporting symptams and receiving a diagnasis was seven years.

Drug treatments

These fall inta three categories and can manage symptoms for many sufferers, althaugh they da not cure. Since many are designed for short-term use anly, and since symptoms are likely ta return after treatment is stapped, this form of treatment requires canstant management and review.

The most common approach is cantinuous use of oral contraceptives. One large study has shown that amang women who have taken oral contraceptives for a number of years, the incidence af endometriosis is significantly lawer. This is the closest indicatian af a possible preventative measure that there is, althaugh it will be inappropriate for some and unacceptable to others. However, in a significant number af cases of minimal or mild endometriosis, it is effective. This approach alsa includes the use of progestogens, although these are less well talerated because af weight gain, headaches, breast tenderness, maad swings, etc.

Another appraach is the use of andragen-like drugs, eg danazol and gestrinane. These are similar in structure ta testosterone and work by reducing the mid-cycle peaks of gonadatrophins, leading ta a reductian in oestrogen levels. In therapeutic terms, these are as effective as ather drugs but are generally unpopular because of their side effects – weight gain, nausea, hirsutism, voice changes, maad swings, etc. Also, these drugs are cantra-indicated or have to be used with coution in mony patients. The side effect of water retention, for exomple, meons it needs to be used with coution in epilepsy, migroine, and cordiac ond renal dysfunction.

The most recent development in drug therapy has been the use of GnRH (gonadotrophin releasing harmane) analogues, namely buserelin, goserelin, leuprarelin, nafarelin and triptarelin. These work by initially praducing high levels of luteinising harmane, fallicle stimulatian harmane and oestrogen, followed by inhibitian of ganadotraphin release aver twa ta faur weeks. This leads ta law avarian activity and aestragen levels that are too low ta sustain endometrial growth.

The response ta these treatments has been mixed, with some women finding the menopausal side effects intalerable. Hawever, with the recent practice af providing an additional, small amount af aestragen – sa called 'add-back therapy' – these side effects are considerably reduced, and this treatment may naw prove mare generally papular.

Althaugh all af these treatments have been shown to provide effective contral of minimal and mild disease, they each carry a side-effect prafile. While these may appear trivial to some, to the wamen cancerned they add ta the general burden of the disease and, as such, are extremely unwelcome.

Surgery

Amang the many uncertainties surraunding endometriosis, two facts are clear. Endometriomas will not be eradicated by drug therapy and may therefare need to be excised. Moderate and severe endametriasis cannot be managed by drug therapy alane.

There is a grawing trend towards treatment at diagnosis – since the patient is already under anaesthetic and the necessary personnel and equipment on hand. Minimal surgery is commonly by laser. Other farms used are cauterisatian, ablation and excisian. While this practice may be expedient, it carries twa distinct disadvantages.

Firstly, this assumes that the visible disease is symptomatic. This is not necessarily the case, and the expected relief will not accur if symptomatic disease is left. This creates complications far patients and clinicians alike. Was the cause af the symptoms something else? Is there more endametriosis that was not visible at diagnosis? The trend is more cammon in minimal and mild cases af the disease, which are also respansive ta drug therapy. Therefare, secandly, unless she has been consulted priar ta surgery, the waman will nat be offered a chaice af treatment.

In mare severe cases it may be necessary ta perfarm o laparatamy, where two further incisions are mode in the lower pelvis to offord greater access. This is particularly useful where there ore adhesions and endometriomos.

In the most extreme cases, it moy be necessary to remove the uterus, ovories ond Fallopion tubes to remove all the active endometriasis. This is different from the prapasition that simply remaving these argans is as gaad as a cure – the mare cells of endometrium that are left, the mare chance there is that the disease will reactivate when aestrogen-anly HRT is given. Far this reason, same gynaecalogists will delay giving HRT far six manths post surgery to reduce the risk af this. However, this is not universally practised and, in same cases, wamen are infarmed that they have a six-month implant when they recover fram the anaesthetic. Not surprisingly, a significant minarity af women wha underga radical surgery repart recurrence of symptams.

One af the argans mast frequently involved in maderate and severe endometriosis is the bawel. This presents particular problems for the surgeon because af the risk of damage. Reparts fram one major treatment centre suggest that surgery involving the bawel is becaming mare comman and, in some cases, it is necessary to perfarm resectian, as the disease has caused such extensive damage.

Personal impact

For many women with endametriasis it is possible ta lead a full and active life. Management daes nat present a seriaus challenge and fertility is not campromised.

At the ather end af the scale, endometriosis can have a negative impact an a woman's life. Apart from the obvious problems af frequent, sometimes continuous, intractable pain, caurses af drug therapy and varying degrees af surgery, there are a number af emational, psychalogical and sacial implications. Painful intercourse can place an unbearable burden on a relationship. She may alsa have to face the impassibility af canception.

The Natianal Endametriasis Saciety (tel: 020 7222 2781, Helpline: 020 7226 2776) affers advice and suppart to sufferers.

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001.*

ACTION PLAN

1. Monitor all prescriptions for drugs used in endometriosis. Try and establish who may be suffering from endometriosis. What are the incidence rates?
2. What are the major problems that sufferers have?
3. What counselling would you give to diagnosed patients?
4. Have you ever suspected a patient to have endometriosis before an authoritative diagnosis was made? What did you do? Would your approach to such a patient be different now?

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1 Source: Nielsen J/A 1999

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METER AND FINGER PRICKER

Tiptoeing around gout

Primary care pharmacist Mary Allen uses a case history to illustrate how a suspected incident of gout was picked up

Lily is in her mid-60s. She visited Jill's pharmacy during a Sunday rota to purchase a suitable painkiller that wouldn't affect the medicines she was already taking for her long-standing angina. She had a very painful big toe. Lily is overweight, but a non-smoker. She drinks little alcohol – possibly a couple of sweet sherries on a Sunday – and lives quietly with her retired husband.

Prescription

Lily's patient medication record showed her current medicines as:

Tenoretic	1 od
Isosorbide Mononitrate M/R 60mg	1 od
Diltiazem	60mg tds
Glyceryl trinitrate spray (GTN)	prn (1 x 200 dose spray dispensed regularly each month)

Presentation

Lily's toe was red, swollen and very painful with tight shiny skin. She had not suffered any trauma. Jill felt that Lily's symptoms were caused by gout.

Possible causes

Lilly had been taking Tenoretic (atenolol 100mg and the thiazide-type diuretic chlorthalidone 25mg) daily for nearly ten years. Thiazide diuretics block the renal excretion of uric acid, with the result that gout is a fairly common side effect.

What should Jill do?

Lily visited the pharmacy on a Sunday, when her doctor's surgery was closed. She needed pain relief until she could see the doctor. The drug treatment of choice for acute gout is a non-steroidal anti-inflammatory drug such as ibuprofen, which Jill could sell to Lily. However, she was reluctant to do so as NSAIDs can antagonise the antihypertensive effects of beta-blockers such as atenolol (in Tenoretic) because they inhibit the renal synthesis of vasodilatory prostaglandins. Aspirin is not useful in gout as it can reduce the excretion of uric acid. Jill advised Lily to take paracetamol until she was able to visit the doctor.

She recommended that Lily continue taking the Tenoretic until she saw the doctor, because she knew that stopping the atenolol component suddenly could cause problems. Discontinuing beta-blockers abruptly can result in rebound tachycardia, hypertension and angina. It is better to decrease the dose slowly over two weeks.

During a quiet moment the next day, Jill contacted the prescribing doctor who was from a surgery on the other side of town. She did not know him very well, but he had a reputation for being arrogant, so she took a deep breath before phoning. True to form, he wasn't prepared to discuss the case but decided to contact Lily to advise her to stop the Tenoretic immediately. Despite this, he was not prepared to prescribe atenolol on its own. Jill boldly reminded him about the risks of abrupt discontinuation, but he felt the risk was low.

Later that day Lily rang Jill to say that her doctor had telephoned and had told her to stop taking the Tenoretic, but she felt confused and worried as the label on her medicine advised against stopping. Jill tried to reassure her, but encouraged her to go and see her doctor immediately if she had any chest pains over the next few days.

Are there other potential medication problems?

- **GTN**

Lily had been receiving a GTN spray every month for about a year. Each spray contains 200 doses. She was already taking a long-acting nitrate (60mg daily of modified release isosorbide mononitrate), together with other drugs to control her angina. She should only require the occasional dose of GTN spray to prevent angina pain during exertion or exercise, or to relieve the occasional bout. Frequent use could suggest:

- that her angina was not properly controlled
- that she was tolerant to the effects of nitrates
- that she was over-using it through fear of suffering an attack.

Frequent supply could also indicate that Lily was not complying with the doctor's instructions, but was ordering medicines anyway, to avoid offending him. Jill was only too aware of the incidence of non-compliance among patients – she knew from the quantities of drugs such as beta-blockers returned unused for destruction following a patient's death from a stroke or similar avoidable condition.

- **Diltiazem**

Diltiazem is a calcium channel blocker. Taken together with a beta-blocker such as atenolol, there is the potential to cause bradycardia since both drugs slow the heart. In extreme cases of depressed myocardial function this can result in asystole. Lily had been taking the two drugs together for some years without any apparent problems, so the doctor would probably be reluctant to switch her to another calcium channel blocker such as amlodipine which is not known to cause bradycardia. Jill decided to leave well alone, as Lily had told her she was due to see the hospital specialist in a couple of weeks.

Would Lily benefit from additional medicines?

Lily would probably benefit from taking 75mg aspirin each day. Low-dose aspirin is effective in the prevention of myocardial infarction or stroke in high risk patients. It acts by reducing platelet aggregation through its effects on platelet cyclo-oxygenase and in its inhibitory action in the synthesis of thromboxane A2.

Patients for whom low-dose aspirin is unsuitable include those with a history of peptic ulceration, aspirin sensitivity or blood disorders affecting clotting mechanisms. Although aspirin can exacerbate gout because of its ability to impair the excretion of uric acid, the low doses used for secondary prevention in coronary heart disease are unlikely to cause problems and are outweighed by the benefits.

Lily may also benefit from taking a lipid-lowering drug such as a statin or fibrate if her cholesterol levels are high. Hyperlipidaemia adds to the problems of coronary heart disease and several studies have shown the benefits of these drugs in this condition.

Jill decided against raising these issues with the GP. She did, however, suggest to Lily that she might wish to mention them, together with the frequent use of the GTN spray, to the specialist during her hospital appointment.

A young woman shares her experience of coping with the crippling bone disease after suffering anorexia nervosa

Osteoporosis

At the age of 15 I was nearly 6ft tall and weighed ten-and-a-half stone. I was going on holiday in the summer and decided to go on a diet. It was the first time I had ever dieted, but this was to mark the beginning of my struggle with anorexia nervosa.

Six months later I had lost one stone and my periods had stopped completely. My GP referred me to a psychiatrist but over the next year my weight continued to plummet. By the time I began my 'A' Level course I was surviving on a diet of apples and soup. When my weight dropped to seven-and-a-half stone, I was admitted to a child and adolescent psychiatric unit. After treatment I left hospital having gained two stone but I was far from being on the road to recovery and my problems were to recur.

Finally, at the age of 19, I achieved a stable weight and was eating well. I started college to re-try for my 'A' Levels and it really seemed to be a new start for me. I was also working part time in a residential home. It was here that I first noticed some back ache, which I put down to my work lifting the patients. Then one morning, as I was getting ready for college, my back completely gave way. My GP diagnosed a slipped disc and prescribed bed rest. It wasn't until I was up and about again that my mother noticed that I was no longer taller than my sisters.

Eventually the diagnosis of osteoporosis was made. Compression fractures in my spine meant I had lost two inches in height. Since then I have been prescribed high dose contraceptive pills and have taken regular exercise and had a calcium rich diet. Scans have shown my bone density is increasing.

Discovering that I had osteoporosis was obviously a horrendous time for me but I now feel very lucky to have recovered from anorexia and to be able to improve my bone density. I have gone on to start a career in medicine and hope that by sharing my own experiences I can perhaps, in some small way, help other young women.

RESOURCES

- **National Osteoporosis Society.** PO Box 10, Radsfock, Bafh BA3 3YB. Tel: 01761 471771. Helpline: 01761 472721. Works to improve diagnosis, freafmenf and prevenfion of the disease. Produces information leaflefs and runs local patient groups.
- **The Pennell Initiative for Women's Health.** Health Services Management Unit, University of Manchesfer, Oxford Road, Manchesfer M13 9PL. Tel: 0161 275 2910. Looks after fhe interesf of older, posf-menopausal women.
- **WellBeing.** 27 Sussex Place, Regent's Park, London NW1 4SP. Tel: 020 7262 5337. Healfh research charity for women (and babies), acts as the research arm of The Royal College of Obstetricians and Gynaecologisfs.
- **Amarant Trust.** 11-13 Charterhouse Buildings, London EC1M 7AN. Advice Line: 01293 413000. Fax: 020 7490 2296. Also 24 hour helpline giving recorded information on 0891 660620 (premium rate call). Runs menopause counselling and hormone replacement fherapy (HRT) clinics.

Private & confidential

The Code of Ethics is currently undergoing a thorough review, however, some issues will continue to be at the heart of pharmacy practice. Patient confidentiality is discussed by Ruth Rodgers, consultant pharmacist and former head of ethics at the Royal Pharmaceutical Society

Principle 4

A pharmacist's prime concern must be for the welfare of both the patient and other members of the public

A pharmacist must respect the confidentiality of information acquired in the course of professional practice relating to a patient and the patient's family. Such information must not be disclosed to anyone without the consent of the patient or appropriate guardian unless the interest of the patient or the public requires such disclosure

In 1951 the European Convention for the Protection of Human Rights and Fundamental Freedom was drafted after the Second World War. On October 2, 2000, this will be incorporated into English law as the Human Rights Act 1998. Article Eight gives individuals a qualified right to privacy, which would otherwise be over-ridden – for example, in the interests of public safety or in an effort to protect the rights of others and to prevent crime.

The circumstances in which information held in the pharmacy may be made available to other persons are governed by Principle 4 of the Code of Ethics in addition to any legal requirements. Although prepared long before the Human Rights Act was written, this principle can be seen to be very much in line with that article of the Act.

Pharmacy records

The principle has grown in importance and impact over the years. Before computers were available for use in dispensaries, and that has only come about in the past decade or so, any records kept by the pharmacy relating to dispensed NHS prescriptions were made manually. Most pharmacies resorted to some sort of record only for patients prescribed unusual or special items, but for the majority no record was kept.

Private prescriptions were, of course, subject to a mandatory manual record in the Private Prescription Book as required by section 66 (1) (i) of the Medicines Act 1968. Supplies of Controlled Drugs have also been subject to records being kept in the Controlled Drugs (CD) Register.

The lack of specific records did not mean, however, that pharmacists were not privy to confidential information about their clients. Potentially confidential information is passed every time a customer consults a pharmacist – and it is not up to the pharmacist to decide what information that a customer has provided is to be considered confidential.

However, there has always been an implied obligation on any pharmacist, whether specified in writing or not, to maintain confidence. Indeed, this requirement is common to many professions. However, the boom in computerised records has led to an increase in the volume of information held and to an increasing demand for that relating to individuals. In addition there has been increased sensitivity by many people about the information held and whether this might be used to their disadvantage in some way.

It is not only individual patient records that may be accessed via the dispensary computer system. Information relating to the prescribing practices of individual or even groups of doctors can be identified and this is also considered to be confidential. The Data Protection Act 1984 and the Access to Health Records Act 1990 govern access to data held in computerised systems.

Information about patients may also be held as paper records, for example in the private prescription book, or in the memory of the pharmacist and his staff. The general principle of non-disclosure to third parties holds good whatever the repository of the information. However, questions will arise from time to time about the extent to supply such information without the individual's specific (or even general) consent to a third party.

Principle 4 of the Code of Ethics, through its five obligations and detailed guidance notes, sets out to deal with the circumstances in which it may be felt necessary to divulge confidential information.

Examples

In practice few cases have resulted in disciplinary action being taken against the pharmacist involved. One which does come to mind concerned information obtained from a CD Register about medication taken by a fellow pharmacist. The pharmacist, while working as a locum, discovered that a hospital colleague was regularly being prescribed high doses of a CD. He was concerned as he believed anyone taking such high doses would be unfit to hold a responsible situation. The locum faced a dilemma about informing anyone else of this knowledge.

Whether he had an obligation to do so on the grounds of concern for patients or others, would depend on the circumstances and is not considered here. However, the locum went back to the hospital pharmacy and discussed the information with the pharmacy staff. This was considered to be a breach of the obligation of confidentiality as imposed by the Code of Ethics.

Another example is related to the delivery of dispensed ostomy bags to a patient. The patient was out, the pharmacist had not agreed a delivery time but thought he would save the patient a journey by dropping the boxes off on his way home. They were taken in by a neighbour who had been unaware of the patient's condition. Needless to say, the patient was concerned a the result of this 'good deed'.

Recently the situation concerning the supply and sale of anonymised prescription data has been the subject of legal action. This was due to a company wishing to challenge guidelines produced by the Department of Health under which such sales were prohibited on the grounds that they would breach patient confidentiality. The High Court, in May 1999, had found for the DoH but in Decembe three judges in the Appeal Court found that the pharmacist's duty of confidence would not have been breached. This judgement related t the specific circumstances in whic a particular company wished to obtain information. However, the principle appears to have now bee established in law, that the pharmacist is at liberty to disclose anonymised prescription data.

These three examples illustrate some of the difficulties surrounding the issues of confidentiality of information within the pharmacy. As well as guarding themselves from breaching their professional obligations, pharmacists should ensure that pharmacy staff are aware how this might relate to the

Reticence over folic acid and heart disease

Folic acid may help prevent cardiovascular disease but there is not enough evidence to recommend adding it to foods for this reason alone, an expert group has decided.

The Committee on Medical Aspects of Food and Nutrition Policy (COMA) recently recommended that fortifying flour with folic acid could significantly reduce the numbers of babies born with neural tube defects (*C&D* January 22, p6). But the Committee stopped short of recommending this action to prevent cardiovascular disease, while acknowledging "there is reason to hope that such an increase in dietary folate would be beneficial".

Folic acid reduces raised blood homocysteine levels, which have been associated with an increased incidence of heart disease and stroke in several studies. Homocysteine can promote the formation of atherosclerotic lesions, alter antithrombotic mechanisms and reduce production of the natural vasodilator nitric oxide.

But in its report, 'Folic acid and the prevention of disease', COMA says there are still problems in determining the exact connection between raised homocysteine, folate and cardiovascular disease: "It would not be justifiable at present to advocate dietary fortification with folic acid solely with the aim of reducing cardiovascular disease."

Several studies have shown poor folate status in people with a variety of neuropsychiatric disorders, but again the report describes the possible benefits of folic acid as "speculative".

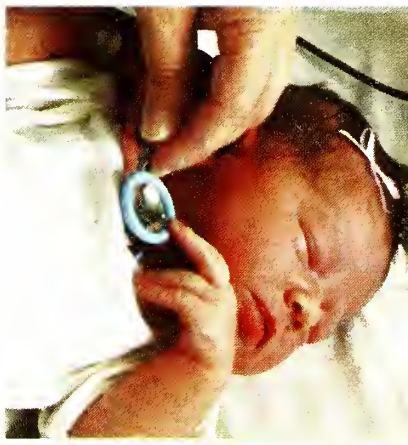
For neural tube defects, the Committee decided that fortifying flour with 240mcg folic acid per 100g would reduce the risk by 41 per cent without harming other sectors of the population.

There are still between 600 and 1,200 recognised neural tube defect pregnancies every year in the UK. This risk could be halved if women took 400mcg folic acid daily in addition to the usual dietary intake of about 200mcg.

But giving all women of child-bearing age an intake of 600mcg daily by fortifying flour could put older people at risk. It might make vitamin B12 deficiency less easy to detect, particularly in the over 50s, by delaying the onset of anaemia.

"The possibility that prolonged intakes in excess of 1mg a day might precipitate neuropathy in some people deficient in vitamin B12 cannot be discounted," the report adds.

A further concern is that some patients taking anti-epileptic medication might need to change dosage, but "regular monitoring and adjustment of such medication is already established as part of good clinical practice".



Women who could become pregnant should therefore still take 400mcg daily of folic acid before conception and until the 12th week of pregnancy. Those who have already had a pregnancy affected by a neural tube defect should take 5mg daily.

Continued on PVIII →

Continued from PVII

The Government campaign to encourage women to take the vitamin has had some success, with sales of the 400mcg supplements increasing by 47 per cent since 1995. But half of all pregnancies are unplanned and by the time a woman knows she is pregnant it might be too late for folic acid to be effective.

The report also considers ethical issues: "Some people might question the propriety of manipulating the diet of the entire nation to compensate for the small number of women who do not follow well-publicised advice to take folic acid supplements if exposed to the possibility of becoming pregnant. Not all women, however, are aware of the significance of the advice."

Food sources

Good food sources of folate are Brussels sprouts, asparagus, spinach and kale (more than 100mcg a serving). Other fruits and vegetables containing significant amounts include broccoli, spring greens, cabbage, cauliflower, iceberg lettuce, parsnips and oranges. Liver, yeast and beer are also good sources. In the British diet the main sources are cereals and vegetables, which each contribute about one-third to the estimated intake of 200mcg.

About 80-90 per cent of breakfast cereals are fortified with folic acid, which is more stable and has a higher bio-availability than food folate.

Bacterial resistance blamed on absence of novel antibiotics since 1960s

The rise in bacterial resistance is being blamed partly on the fact that no new classes of antibiotic have emerged since the 1960s.

In an editorial in the *BMJ* (2000, 320: 199-200), Professor Sebastian Amyes of the medical school at the University of Edinburgh, argues that no new clinically useful structures of antibiotics have been introduced since 1961, all antibiotics introduced since that date being modifications of existing ones. This has meant that microbes already resistant to one antibiotic do not have to 'learn' much more to overcome the new modifications. "At the end of the 1960s we did not realise that we would face the next three decades with much the same antibiotic groups as we had then... If bacteria were challenged with a new antibiotic class, there would be little chance of cross resistance."

Professor Amyes also blames the rise of resistance on the introduction of organ transplantation in the 1960s, which involved the aggressive use of antibiotics to control infection in the immunosuppressed patient. This, he believes, led to the rise in resistance of some of the well-known hospital pathogens, such as methicillin-resistant staphylococci and vancomycin-resistant enterococci.

The spread of multiresistant bacteria has also been facilitated by hospital designs, which move patients closer together and rely on regular transfers of patients between different points of treatment.

The author concludes that increased understanding of molecular biology and bacterial genomes will help shed light on the mechanisms of bacterial resistance.

CHD deaths peak on Mondays

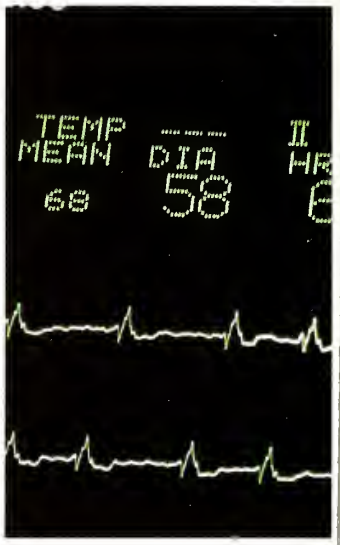
Deaths from coronary heart disease peak on Mondays in Scotland, possibly because of increased drinking at the weekend.

Researchers from the Information and Statistics Division at NHS Scotland and the University of Glasgow analysed deaths from coronary heart disease in Scotland and found 91,193 deaths among men and 79,051 deaths among women from the disease between 1986 and 1995.

On further investigation, they found an excess of such deaths on Mondays in both sexes and in particular among those who had not been admitted to hospital with the disease before or who had died outside hospital. There was also an excess on Mondays for patients under the age of 50. Tuesdays saw the least deaths from CHD in both sexes.

This 'Monday' excess is thought to be partly due to excess drinking at the weekend but other mechanisms, such as work related stress, may also be involved.

Several potential mechanisms have been put forward linking CHD death with binge drinking and withdrawal. The authors, writing in the *BMJ* (2000, 320: 218-219) conclude that such an association has potentially important health implications and merits further investigation.



Faecal H pylori test is effective

A new faecal antigen test for *Helicobacter pylori* is almost as effective as the ^{13}C-urea breath test, according to a study in the *BMJ* (2000, 320: 148).

The study screened 90 patients with dyspeptic symptoms for *H pylori* infection with both tests. Fifty-one patients produced a positive breath test, and in 47 of these, the *H pylori* antigen could be detected with the faecal test. Of the 39 patients with a negative breath test, 38 were *H pylori* negative in the faecal antigen test.

In a separate part of the study, 115 patients with *H pylori* infection were treated with a triple therapy – omeprazole 20mg twice daily, clarithromycin 250mg twice daily, and metronidazole 400mg twice daily for seven days. After treatment, 92 patients presented with a negative breath test. Among these 92 patients, there were two false negative and five false positive antigen test results.

The researchers concluded that the faecal antigen test is a sensitive and specific technique for the qualitative detection of *H pylori* infection, even for monitoring efficacy of treatment. At about £19, it is cheaper than the ^{13}C-urea breath test and easily performed in any laboratory. Overall sensitivity and specificity of the test were found to be 91.5 per cent and 95.4 per cent respectively.

PHARMACYupdate: distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, *C&D*'s readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the March 11 issue, which will cover this week's CPP-accredited modules, together with those in the February 5 issue.

In other words:

- Allergies in the home (1152)
- Chronic daily headache (1153)
- Endometriosis (1154).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

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Clinical governance – what it means to you

Some pharmacists are worried that clinical governance might turn into a heavy-handed policing exercise. Adrienne de Mont investigates whether or not their fears are justified

The Royal Pharmaceutical Society stresses that the questionnaire seeking information on how community pharmacists comply with clinical governance principles is merely a "tool" to help pharmacists discover where they stand in relation to others (*C&D* January 29, p5).

The questionnaire, being issued to local pharmaceutical committees and pharmaceutical advisers, asks searching questions about whether pharmacists are taking part in continuing professional development and what procedures they have for minimising risks.

The results will provide 'model baseline assessments' to enable LPCs and health authorities to find out where pharmacy's strengths and weaknesses lie, so support can be aimed in the right direction.

But some pharmacists are worried about confidentiality and the involvement of the Society's inspectors. Will this mean greater policing and will private business information fall into the wrong hands?

David Pruce, the Society's audit development fellow, stresses that the aim is to help pharmacists implement clinical governance which, essentially, is a local NHS procedure. The survey should provide information the health authorities need to ensure that clinical governance is being implemented locally. LPCs are appointing a community pharmacist as clinical governance lead to liaise with the health authority, rather than the authority having to contact all pharmacists.

"We're stressing that the information pharmacists provide must be kept confidential, so the health authorities won't be able to identify individuals but would be able to identify the main quality issues that needed addressing.

"In turn, pharmacy could use the information to tell a health authority that it isn't giving enough support to audit or CPD, and that the health authority needed to put its hand in its pocket and find some more resources!

Jason Bennion

"Clinical governance also involves risk management and managing risk depends on having adequate procedures in place for such things as dispensing, purchasing medicines from suppliers, health and safety, and dealing with errors and complaints. We're not saying all pharmacies must have procedures, and procedures may be less relevant in smaller independent pharmacies. We do believe, though, that procedures help reduce the risk of mistakes. However, anyone can write a procedure, but whether or not they follow it is a different matter! Our aim is to help pharmacists to see where they stand in relation to others and to consider what they ought to be doing themselves."

So it seems the exercise is not a witch hunt and pharmacists have nothing to fear by being scrupulously honest?

"The Society will not see the individual responses to the questionnaire," he replies. "We would be interested in getting an overview of the results, but only after they have been anonymised. That would help us plan how we can support pharmacists better. It is important for individuals to feel they can be honest and to know their replies will be kept confidential.

"We hope the results will be fed back locally so pharmacists can see what is best practice and what they might aim for. The information will also enable local clinical governance leads to offer practical help," he says.

"Clinical governance should be more about helping everyone rather than catching out the bad guys. We want pharmacists to take it on themselves to improve their practice instead of being forced to by the Society or the health authority."

Inspectors have a major role in reporting poor performance, but their role in clinical governance will be to highlight to clinical governance leads the main problems they see in their own areas. For example, they may notice a general problem over MDS labelling that affects several pharmacies. Inspectors will not discuss an individual's performance (they are prevented from doing so under the Medicines Act), but will be able to point out common issues that need working on.

The Society will carry out another survey later this year to see how many clinical governance leads have been appointed and what support they need.

HAs and PCGs have responded well to the Society's 'Achieving excellence' document and have requested a further 400-500 copies.

"That's a brilliant response," he says. "We know it has reached the right people and been read."

In Wales, local health groups are appointing clinical governance leads who could be anyone on the LHG board with a clinical background, including pharmacists.

"In addition, the pharmacist board member will invariably be involved in a sub-group set up to look specifically at clinical governance. In principle we want the equivalent of the English 'leads' but they will have to be called something else, such as clinical governance pharmacy facilitators," says Erica Barrie, the Society's Welsh Executive secretary.

The LHG pharmacists are already sending out baseline assessments, ahead of the Society in England, as the Wales Office asked for action as soon as possible. Phil Parry, chairman, Welsh Central Pharmaceutical Committee, believes there should be a pharmacist with a facilitation role, distinct from the Society's inspector or health authority, which have monitoring roles.

"Pharmacists need someone with whom they can identify as a friend to help them develop clinical governance," he says. The committee is exploring the possibility of health authorities giving grants to LPCs to pay the facilitators.

In Northern Ireland, delays in establishing the new legislative assembly have resulted in delays in implementing the health service changes proposed in 'Fit for the future', which could take at least another year.

"Clinical governance is a live issue but not as pressing as some others," says Joe Gault, acting secretary, Pharmaceutical Society of Northern Ireland. "It's likely we will follow the route taken in the rest of the UK, along the lines of the RPSGB proposals."

Continued on P20→

→Continued from P19

The Society in Scotland has only just produced its clinical governance framework, but the proposals are similar to those in England (*C&D* January 29, p5). The aim is for health boards to fund a community pharmacist clinical governance lead appointed by the area pharmaceutical committee.

The main pharmacy organisations are collaborating with the Society on a clinical governance working group, whose next meeting is expected to be towards the end of March.

The Pharmaceutical Services Negotiating Committee will put the case for a "light touch system". General secretary Stephen Axon says: "LPCs have expressed concern about the involvement of the Society's inspectors. We want to ensure that clinical governance is not linked to professional discipline and that a blame culture is not introduced. We need anonymised information looking at a general situation so the LPC can make general recommendations. There should be no question of further policing."

PSNC has produced a draft letter for LPCs to write to health authorities, suggesting how LPCs might help implement the Government's clinical governance proposals. Pay for the leads is being negotiated locally. So far about half a dozen have been appointed and are being funded, but the PSNC is still collecting information on how much they are getting per session. Bucks LPC has been given £10,000 to look at the whole concept of clinical governance in pharmacy, including audit.

The National Pharmaceutical Association is looking closely at the matter, but is waiting for more specific guidance from the Department of Health on the likely implications for pharmacy.

Colette McCreedy, head of the practice division, says: "We are collaborating with the Society and monitoring developments as closely as we can, so that when a clear plan emerges we can help pharmacists in a practical way. We will probably do this by producing a resource pack to help our members deal with requirements."

Local approaches

Liverpool LPC has written to the health authority chief executive outlining plans and saying it will "embrace the concept of clinical governance with enthusiasm".

Liverpool LPC secretary Jeremy Clitherow says the company chemist representatives have had doubts about disclosing information, firstly, because they are reluctant to let other contractors have access to commercially sensitive data.

"A lot of this is misplaced nervousness," he says. "What we need are generalisations and not statistics."

Some pharmacists are dubious for political reasons. "If information is in the public arena, it could alert potential leapfroggers to services that are lacking. They could then apply for inclusion on the pharmaceutical list, arguing that they could provide the services. But in the real world, if there is a need for a service someone will be able to identify it anyway.

"Independents are often nervous about anything new. They need to have confidence that clinical governance is not meant to be threatening, judgmental or intrusive.

"The problem is that if we as LPCs don't grasp it ourselves, then the chief executives of health authorities, who have been entrusted with implementing clinical governance, will have to make sure all contractors participate. The chief executives will delegate it to the medics, but your friendly GP will be unlikely to do it personally. Heaven forbid that he [or she] might pass the duty on to the practice manager or nurse.

"Politicians, too, might bring in clinical governance through the back door and make it part of our terms of service, demanding an accredited level. This might be fine for an active pharmacist, but what about the retired locum who steps in for a quiet Saturday afternoon? Suddenly the proprietor finds the locum is not a qualified person because he has not got accreditation," he warns.

The next step in Merseyside will be for the Society's inspector to talk with the six LPCs about how pharmacists might be brought up to speed. When it comes to clinical updates, Mr Clitherow believes pharmacists should concentrate on the most commonly used drugs in their area, as identified by PACT data, rather than randomly working through *BNF* therapeutic categories.

Andrew McCoig, Croydon LPC secretary, finds clinical governance something of a turn-off.

"It is simply a revival of the old style audit in another more fashionable form," he says. "The clinical governance agenda appears to imply that the screws should be slowly turned on all professionals to try to extract additional value and quality without the need for proper investment in the services they are trying to provide."

Pharmacists already have a professional framework issued, rightly, by the Society and set out in the Code of Ethics. He argues that, at the present level of dispensing fee, there is little room for qualitative improvements in the pharmaceutical service.

"Much thought has been given locally to improving the way community pharmacists deal with asthma patients, so that the standards of pharmaceutical care are raised to reflect current knowledge about disease management. In principle all pharmacists, including myself, acknowledge that more could be done in the pharmacy for asthma sufferers. The reality is that, for £0.97, there is no incentive for any kind of additional service, advice or help for patients in this category."

He continues: "Unless the health authority or local PCGs approach us with a meaningful package concerning extended care into which we can weave clinical governance, there is little need for me to spend any of my waking hours worrying about additional burdens on hard pressed contractors."

That said, his LPC has already appointed a clinical governance lead.

Background

The Government's drive to improve the quality of the health service is based on clinical governance.

Health professionals are expected to set up:

- **comprehensive programmes of quality improvement activities such as audit, continuing professional development, evidence-based practice, research and effective monitoring of clinical care**
- **clear policies aimed at managing risks**
- **procedures to identify and remedy poor performance.**

Last September, the Royal Pharmaceutical Society proposed a framework for pharmacists in the document 'Achieving Excellence in Pharmacy through Clinical Governance'. It proposed that the local pharmaceutical committee should nominate a local community pharmacist as clinical governance lead, to be funded by the health authority for at least one or two sessions a week.

The clinical governance lead would:

- **ensure that suitable mechanisms were in place to support community pharmacists in quality improvement activities**
- **report to the health authority on the quality of local pharmaceutical services.**
- **identify and offer support to rectify poor performance**
- **report persistent poor performance to the Society and health authority**
- **liaise with the primary care group over how community pharmacy links in with the overall clinical governance of patient care**
- **support pharmacists on PCG, primary care trust and local health group clinical governance committees.**

Inspectors will remain the main means of identifying poor performance and encouraging improvement, but the Society wants the power to fine or take action against pharmacists with poor standards. These powers are being discussed as part of general disciplinary reforms.

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A Worcester pharmacist is a key figure in a Healthy Living Centre bid. Hooman Ghalamkari tells Steve Bremer the advantages of this novel source of funding

At the centre of healthy living

A Worcester pharmacy involved in a £0.5m Healthy Living Centre bid has impressed local authorities with the healthcare services it can offer. The authorities are so keen on sustaining funding for these services that they are proposing lobbying parliament to change pharmacists' terms of service.

Proprietor of DG Pharmacy in Dines Green, Hooman Ghalamkari plans to offer a range of pharmacy services as part of the Worcester Regeneration Partnership's Healthy Living Centre Bid. Although the bid is for a three-year project, it must be sustainable after this time. One suggested method of sustaining the bid's pharmacy element is to campaign for extended roles payments to be included in pharmacists' remuneration.

Another possible method of sustaining the services would be research funding. For example, a research bid could pay for a pharmacist to evaluate projects. While one pharmacist takes over dispensing, the other could run additional services. Primary care groups could also be a source of funding.

The Worcester Regeneration Project includes representatives from the city and county councils, local health authority, the voluntary sector and the local constabulary. These organisations are important to the bid because they will help sustain the pharmacy services. "We are always striving to get paid for these extended roles, but the HLC can pump-prime the roles and the WRP will sustain them," says Mr Ghalamkari.

Those involved in the bid must show their commitment to the project. Mr Ghalamkari has shown his commitment by adding two consulting rooms to his pharmacy. The rooms will be leased initially to a private chiropodist, homoeopath and reflexologist, but he hopes to eventually rent the rooms to NHS practitioners.

The health authority has donated a full-time health promotion worker to the project. And the council is committed to the administrative and secretarial work involved. While most of the money for the project will come from the Government, everyone involved is contributing something.

> "If you are seen as and initiator of the HLC, people will regard you as someone who is interested in their health"

Pharmacist Hooman Ghalamkari plans to offer a range of services as part of the HLC bid

Mr Ghalamkari is proposing to introduce the sort of services that pharmacists already provide in their day-to-day practice. "These are things we are already doing for free; all we are doing is formalising it."

Pharmacy services that form part of the bid include a minor ailments clinic, health information and promotion services, smoking cessation services, one-off campaigns such as asthma clinics, and clinics offering services such as chiropody and dentistry.

The pharmacy section of the project is worth about £200,000. A bid of £10,000 annually per pharmacy has been submitted to run minor ailments clinics, plus a further £8,000 for their evaluation. For IT, the bid is £2,500 per pharmacy for initial set-up costs, such as the purchase of computer equipment.

During the project's first year, DG Pharmacy will act as a pilot, with the model being adapted as it is rolled ou across Worcester. As the scheme is extended, pharmacists will be encouraged to "buddy up" with other in the area. This "buddying up" process has already begun through a smoking cessation scheme that involves co-operation between five pharmacies in Worcester.

Mr Ghalamkari expects to hear if the bid has been successful by early February. If the initial bid is accepted a more detailed plan must be submitted. Money would become available next year.

What is a Healthy Living Centre?

- Healthy Living Centres will contribute to inequalities in health. Priority will be given to projects that focus on areas of deprivation, and the needs of people who experience worse health than average.
- There is no central blueprint for projects. Centres will be independent. The Government wants to encourage innovation and energy in developing new and imaginative ways of responding to local needs.
- Bids are welcome from a range of organisations, and local interests in voluntary, public and private sectors will be encouraged to work together. HLCs will foster partnerships across different groups that together can create new ways of providing attractive facilities and services.
- £300 million has been allocated to the initiative. Of this, £200m will be made available by 2001 and £100m after 2001.
- The HLC initiative at the Department of Health and the New Opportunities Fund at the National Lottery are administering bids.
- The New Opportunities Fund gives guidelines on what an application should demonstrate: "Robust local partnership, co-ordination with local and regional strategies, strong community involvement, innovation, a clear understanding of the communities or groups who will benefit, firm evidence of succession planning, and sound proposals for local evaluation."

History of the bid

The idea for the Healthy Living centr came from a head lice health promotion project that included DG Pharmacy, the local school, community centre, church, health authority, health visitors and parents

Continued on P24

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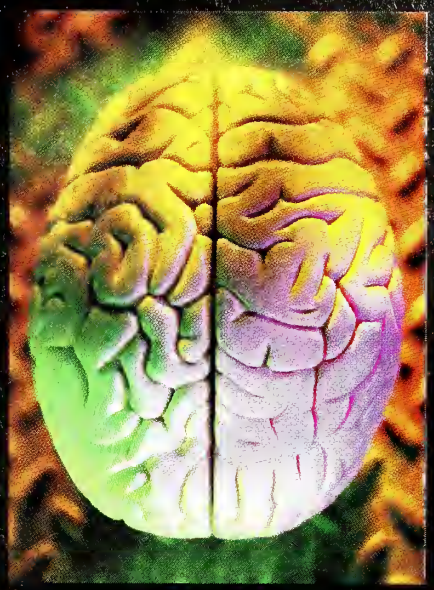

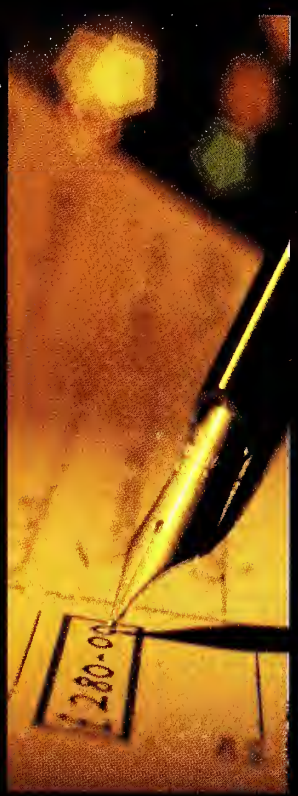

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→Continued from P22

(*C&D* April 25, 1998, p5). "The project was innovative because it was something the community wanted to tackle – it was a health need [rather than coming] from the health authority or above."

Following the success of this project, the group decided that the HLC initiative would be a logical source of funding to tackle other health issues. "That is what HLCs are all about – local communities voicing their needs, taking responsibility and tackling issues themselves." It was felt that the head lice model could be used for other projects.

Dines Green is an ideal location for an HLC because the initiative was launched to tackle the link between poor health and social deprivation. The area has one of the most socially deprived populations in Worcester.

The next step was to determine the needs of the local community and how to address them. A seminar was held in January attended by representatives from organisations including the local council, health authority, NHS Trust, and members of the community (see *C&D* February 13, p6).

People were asked what services they would like provided in Dines Green. Not all the ideas were purely health issues, but included those that would impact on health. For example, debt advice, accident prevention and pavement repairs were all mentioned. These would all indirectly improve the health and wellbeing of the community.

After the seminar, proposals were put forward that would use the community's existing services and personnel. The concept of "social businesses" was proposed, and the bid was designed to encourage, develop and formalise the work of these businesses. The five social businesses are the pharmacy, the primary school, the co-operative supermarket, the community centre and local pubs.

Proposals included making the school a centre for life-long learning, providing adult education, internet access, and crèche facilities. DG Pharmacy would be developed as a reach-out/step-in resource, and the pubs would offer community leisure opportunities, particularly sport.

Each social business will be used to monitor the scheme's progress. Prescription statistics from the pharmacy can be used to monitor changes in health status of the community. For example, the number of contraceptive pills dispensed could be used to evaluate the success of a contraceptive awareness project. A reduction in the number of anti-social drink related incidents would be a measure of the success of the pubs' involvement. Attendance registers would monitor the life-long learning centre's progress.

Who is involved in the bid?

Involvement has been at both local level and organisational and policy level. At the local level, the most active players have been:

- Mr Ghalamkari
- the community worker
- the head teacher
- the youth worker
- local councillors
- local housing office.

At the organisational and policy level, key players have been:

- The Worcester Regeneration Partnership, which includes representatives from the city and county council, the health authority, the probation service, the local constabulary, Chamber of Commerce Training and Enterprise, and the City of Worcester Volunteer Bureau). It aims to "reduce inequalities and differences of achievement between neighbourhoods and bring relative economic prosperity and social well-being to all communities"
- Worcester Royal Infirmary NHS Trust. The Infirmary has been recognised by the WHO as a health promoting hospital. Chief executive of the NHS Trust, Mark Butler, says: "Given the hospital's commitment to acting as an advocate for health promotion in the local community it is only natural that it should support the development of the 'Healthy Living' concept. The hospital is keen to work with the local people, health and social care agencies and local enterprises to promote healthy living"
- Warcestershire Health Authority
- Worcestershire NHS Community Trust
- Worcester City Council will manage the bid. It will do the administration and office work. A project officer will ensure that ideas are implemented and will be accountable to the managing board, who feed back to the WRP. This structure of accountability is important and is included in the guidelines for submitting a bid. The project manager would also be able to submit bids for research grants.

Changing practice

Mr Ghalamkari describes the Healthy Living Centre as a "completely new approach to dealing with health issues. It's about changing practice and that's why I'm so excited about it". Pharmacists are currently constrained by the limitations of their terms of service, he says. "We are moving away from the medical model

f wellness and looking at wellbeing. This means getting closer to people nd their local communities."

Organisations like health authorities eed to hear from the public about ieir needs, and pharmacists are well laced to communicate these iessages. "I've almost become a voice or the community, articulating their eeds," says Mr Ghalamkari.

'Knock-on' effects of the bid have enefited DG Pharmacy. "If you are seen as an initiator of the HLC, people will regard you as someone who is interested in their health and that's exactly the image I wanted to project."

Other services included in the bid are a health information library, consulting rooms for other healthcare personnel, acting as a focus for health promotion projects, and training of volunteer health advisers. IT links with the health authority would allow patients to access its health promotion library.

Since the bid's inception, the project has been renamed the Worcester Healthy Living Network, as "centre implies a building and that's the wrong word for it - it should be a locality". But because there is no model for an HLC, there are no limits to what form it can take.

Other pharmacists interested in preparing a bid must link in with people at ground level, such as GPs, local schools and clinics. But it is also important to work with the authorities. "I'm sure that in most areas there is an organisation like the WRP who would be delighted to hear that there are people on the ground interested in these issues," says Mr Ghalamkari.

The National Opportunities Fund can provide an information pack that contains guidelines on submitting a bid. The HLC initiative office at the Department of Health can also advise, as can the National Pharmaceutical Association.

NPA workshops have resulted in about 17 pharmacists becoming involved in local projects. In some cases, the LPC took the lead, while in others individual pharmacists have moved things forward. Work is being done in Battersea, Cannock, Wakefield, Doncaster and other areas.

● *Anyone interested in setting up their own Healthy Living Centre can contact Mr Ghalamkari for advice on 01905 749077.*

Copies of on HLC report by the NPA are available from its professionol development department. This exploins whot is involved in HLCs, obout the bidding process, ond how pharmacists can get involved. Contoct 01727 858687, ext 339 or 217.

Ir Ghalamkari's pharmacy in Dines Green is an ideal location for a Healthy Living Centre

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Clarification needed regarding PI over-labelling

Your issue of *Chemist & Druggist* February 5 (p24) contains a news item reporting that the Medicines Control Agency will no longer reject applications for a parallel import because individual strips are not over-labelled. This requires further clarification.

Following advice from the European Commission, in December last year we issued advice to parallel import licence holders about over-labelling of blister strips.

We explained that it is no longer a requirement to include the name of the parallel importer on the blister strip, as long as it appears on the outer packaging and the user package leaflet. We would not, therefore, refuse to grant such a licence to import solely on the basis of a failure to include the parallel importer's name on the blister strip.

Although we will no longer insist on the name being on individual blister strips, we nevertheless believe that over-labelling in this way is useful – not least because of the potentially significant implications for the importer in the event of a batch recall.

If the parallel importer is not identified on the blister pack and the carton and leaflet are not available, all holders of PI licences will have to be contacted and each one asked to recall stocks of the implicated batch. There is, therefore, considerable merit in continuing with current practice.

Dr Keith Jones
Director and chief executive, Medicines Control Agency

Praise for Xrayser's vigilance on Drug Tariff matters

With reference to **Xrayser**'s article in *Chemist & Druggist* February 5 – 'Time for Tariff to get real' – I am pleased to report that the *Drug Tariff* is catching up.

The preface to the February 2000 *Drug Tariff* gives advance notice that from March 1 enalapril maleate tablets 10mg and 20mg will be category A. This month the PSNC agreed that from April 1 (with advance notice in the March *Drug Tariff*) enalapril maleate tablets 2.5mg and 5mg and fluoxetine 20mg capsules will be category A.

Xrayser is to be congratulated on his continuing vigilance on *Drug Tariff* matters.

Gordon L Geddes
Head of information and technical services
Pharmaceutical Services Negotiating Committee

Prancing around London in lace-up leggings and a gold laurel wreath might not be everyone's idea of fun, unless you happen to be on a mission, like the 'Zovirax Cold Sore Cream Warrior' above. Delivering the new A-Zovirax Guide to Cold Sores (call 0845 603 0052 for your copy) on St Valentine's Day does not really strike the right romantic note, though! Maybe pharmacy assistants (l-r) Elpida Polokytha, Rashmi Bhudia and Katerina Ecomomou from the Apek Pharmacy on Praed Street, London, had other things on their mind?

Web site offers pharmacists up to 3,000 generics/PIs

Alliance UniChem's former corporate development manager, Musa Dhalla, plans to launch a web site that will act as an intermediary for pharmacists wishing to buy generics and parallel imports.

Mr Dhalla's North London-based company, Pharmalife, has secured investment worth £1.5 million from Atlas Venture, the international venture capital group that is already behind the imminent UK launch of healthcare site *planetmedica.co.uk* (*C&D* January 29, p28).

Atlas has taken a majority stake in Pharmalife - the remainder is owned by Mr Dhalla, a trained pharmacist who left Alliance UniChem last year. The company currently has four staff and is recruiting more.

Pharmalife's trading web site - *www.tradepharm.co.uk* - is due to go live by June and will offer pharmacists up to 3,000 generics and PIs. The company said the products would represent 45 per cent of the items dispensed in a typical pharmacy.

Pharmacists will have a free subscription to the web site: they merely log on, identify which product/products they want to buy and choose which supplier/suppliers they want to buy them from. The system then provides a list of the preferred order, which includes the prices, and the pharmacist then decides whether to take up the order.

Mr Dhalla said the generic/PI market lacked a "central market place for trade buyers and sellers to make and locate their purchases. Tradepharm provides that, whether we sell products or pass on information".

Pharmalife is talking to manufacturers, wholesalers and buying groups to see who wants to be involved. Mr Dhalla would not be drawn on names.

The suppliers will be charged commission fees, which are currently being negotiated, on products they sell through the web site. Mr Dhalla said their response had been positive - they were not put off by the charges.

"Suppliers [involved in the web site] could reduce other costs they're currently meeting on reaching their target audiences, eg through sales reps. They see it as a new channel for reaching pharmacists," he said.

The technology also meant that suppliers could change their prices quickly - they would be encouraged to make their prices as competitive as possible.

On-line advertising will be another source of revenue for Pharmalife.

Pharmacists in turn would appreciate the service because they would have more information about generic prices. "Pharmacists usually trade with one or two [generic/PI] suppliers, so they're not making optimal choices in many cases. By giving them better information they can make better choices," he said.

The site will also allow pharmacists to liaise with each other to sell slow-moving stock. And it will offer planograms, geo-demographic information and other services - supplied in conjunction with manufacturers and healthcare information specialists - to improve the pharmacy business.

Mr Dhalla reckons the whole web site package could improve the profits of an average pharmacy, with an annual turnover of £500,000, by £5,000.

A complementary web site - *www.pharmalife.co.uk* - will also be launched to provide information that will help the pharmacist to run the business. This site will use library resources, training materials, career management advice, and news and information.

Mr Dhalla aims to launch similar web sites throughout Europe.

Musa Dhalla, Pharmalife's chief executive

IN BRIEF

Gehe profits up 15 per cent

Gehe's pre tax profit rose around 15 per cent to ✳260 million (£160 million) on a turnover of ✳13.8 billion last yeor, according to provisionol figures. Its phormoceuticol soles were up 10 per cent. The group's double-digit increoses were obove its expectations – it hod predicted soles to rise around 7 per cent and profits by obout 6.6 per cent. Full details are expected in March.

Nucare offers holiday service

Pharmacy symbol group Nucare is offering, through its members, o holiday ond travel booking service with Go Direct, the low-cost oir corrier. Its members display and promote the leoflets concerned, olong with o window poster. Customers who toke up the offer deol solely with Go Direct. Nucore's members receive o 15 per cent commission on each holiday booked through their outlet.

Aventis sales force for OTCs

Aventis Pharma, the group formed last yeor when Rhône-Poulenc merged with Hoechst, hos set up o soles force to sell its OTCs: Brolene, Dioralyte Relief, Opticrom, Rynocrom, Anthison and Phenergan Nightime. The reps will be supported by o telesoles team.

Norton launches hi-tech stock system

Norton Healthcare has introduced a paperless, computerised warehouse system that is expected to increase its picking accuracy to 99.9 per cent.

The company has invested £500,000 in the new system - Opus - which partly involves installing barcodes on its stocks. Each warehouse shelf, meanwhile, has its own code. The company's warehouse workforce use hand-held computer terminals whose screens tell them which shelf to go to and which products to pick. By scanning the stock the staff can check they have picked exactly what has been ordered.

While most major pharmaceutical manufacturers run a similar system, Norton claims to be the first generic producer in the UK to do so.

Graeme Ker, Norton's customer services manager, said the company's former manual system was too labour intensive and slow, partly because it involved so much paperwork. For example, products packaged at its site in Waterford, Ireland, would have to be physically counted when they arrived at Norton's depot in the Royal Docks, London. With Opus the newly-scanned products are counted automatically.

Mr Ker said the new system would benefit wholesalers and pharmacists. "As they need to return fewer goods, this will simplify their financial planning - as we will have to issue fewer credit notes - and cut down the time they spend dealing with these issues," he said.

The company's stock picking is currently about 95-97 per cent accurate, which is equivalent to around 250-300 errors a month.

Opus will also improve Norton's inventory control and speed up the movement of goods through the dispatch system. "Twenty per cent of products account for 80 per cent of orders, so the system ensures that rapidly moving stocks are replenished. This is especially important as pressure on shelf space increases," said Mr Ker.

Better stock information is also expected to give Norton an extra half-a-day's notice on out-of-stock problems.

Its warehouse staff, meanwhile, will be able to handle 30 per cent more work because the system enables them to deal with multiple orders.

Mr Ker said a faster service was vital for the efficient supply of patient packs. Norton now has 30 million packs on its shelves, compared with four million before the Patient Pack Initiative. Such packs account for 8% per cent of its stock and it expects the remainder to switch within the next few months.

Nick Foster, Norton's marketing director, said Opus' efficiency will be essential as it develops its business in Europe.

Norton believes Opus will almost eliminate stock picking error

Businesses face three-year wait for rate appeals

Pharmacies and other businesses could have to wait three years to settle appeals against their new business rates, due to revised appeal procedures, according to chartered surveying company Gerald Eve.

The company said the system was extremely confusing because businesses face new deadlines to lodge their appeals. Only those who appeal within six months of the new rates, which become effective on April 1, will receive fully backdated refunds. Later appeals will get partial refunds, depending on the dates they were submitted.

The Valuation Office Agency, which set the new rateable values and will handle appeals, has prepared an initial three-year timetable to settle them.

Under the current system, businesses can appeal almost any time. Jerry Schurder, Gerald Eve's head of rating, said the changes were creating a complex system that would delay the appeals process.

Businesses, he added, could be further confused by the Government's 'transitional arrangements' which cap rate rates in the first year of the new system, and progressively lower the caps over a five-year period until the company is paying the full amount.

The National Pharmaceutical Association reckons that 40 per cent of premises could pay their rates this way.

Mr Schurder added: "Companies with a low increase in their rates bill in the first year may be lulled into a false sense of security and fail to appeal until it is too late to maximise the savings available." The NPA said the new rateable values are expected to be much higher because rents are relatively high. A comparable reduction in the uniform business rate (UBR), however, will offset the increases.

It said there were three main grounds for appeal:

- the premises' new rateable value is higher than its open market value on April 1, 1998
- the rateable value is higher than that for similar premises
- the premises are potentially harmed by a change of circumstances, eg road closure or building works.

Although a chartered surveyor can suggest whether an appeal is worthwhile, the NPA warns that the cost and time involved in appealing may exceed any benefit gained.

Pharmacists who want to handle the matter themselves can obtain a standard from their Valuation Office, and can discuss their case with a local valuation officer.

The NPA urges pharmacists not to sign up for 'no win, no fee' deals because they always have easily-overlooked clauses that create extra charges.

Gerald Eve, meanwhile, has also criticised the Government for leaving companies to seek out their own rateable values and work out their own rates – under the previous system businesses were told what their new rates would be.

New rateable values were published on the Valuation web site on January 4 (*www.voa.gov.uk*). Gerald Eve has a free internet-based calculator to help companies find their new rateable value, and work out how it will change over the next five years. This can be found at: *www.ratescalc.co.uk*.

- Pharmacists can calculate their new rates by multiplying the rateable value of their premises by the uniform business rate (UBR), which is set every year by the Government. Until March 31 it is 0.474 for England and Scotland and 0.429 for Wales. If the rateable value is less than £15,000 in London or less than £10,000 elsewhere, the UBR is slightly lower.

COMING EVENTS

FEBRUARY 20

Lanarkshire Branch, RPSGB, at the Bothwell Bridge Hotel, Bothwell, 10.30am to 4.30pm.

FEBRUARY 21

Derby Branch, RPSGB, AGM at the European Hotel, 7.30pm.

FEBRUARY 22

East Metropolitan Branch, RPSGB, at the Wanstead Library, Wanstead, 7.30pm.

Fife Branch, RPSGB, at Dunniker House Hotel, Kirkcaldy, 7.45pm.

Slough & District Branch, RPSGB, at the John Lister Postgrad Centre, Wexham Park Hospital, Slough 7.15 for 8pm.

Cheltenham & Gloucester Branch, RPSGB, meeting on 'Clinical governance or martial law?'

NICPPET at The Oaklin House Hotel, Dungannon, 7.30 for 8pm.

Bradford Branch, RPSGB, and the University Pharmacy Practice Dept lecture series at the University, 7.30pm.

FEBRUARY 23

Wirral Branch, RPSGB, open meeting (bring staff and friends). 'Wine Tasting'.

FEBRUARY 24

Edinburgh & Lothians Branch, RPSGB, at the Royal Pharmaceutical Society, 36 York Place, Edinburgh, 7.45pm.

Bedford Branch, RPSGB, at the Conference Centre, Silsoe College, Silsoe, 7.30 for 8pm.

NICPPET at The PSNI, Belfast, 7.30pm.

NICPPET at The Silver Birches Hotel, Omagh, 7.30 for 8pm.

NPA may launch stakeholder pension scheme for owners of pharmacies

The National Pharmaceutical Association may offer pharmacy proprietors a free pension scheme that will enable them to meet new regulations concerning stakeholder pensions.

It is monitoring events as the Government sorts out final details to prepare for April 2001, when employers with five or more staff will be expected to offer them a stakeholder pension scheme. Most part-time staff will also have to be covered.

Stakeholder pensions are aimed at those earning below £18,000 pa, who may not have taken government advice to open private pension schemes. A stakeholder is defined as anyone with an interest in the financial wellbeing of the business, eg employees.

While a pension specialist will run the scheme, pharmacy proprietors will have to administer the pension payments. The NPA said the administration costs should be small.

Pharmacy owners do not have to contribute to the scheme, although they can if they want to. They do not have to worry about a scheme if their employees do not want to join.

Pension schemes run by relatively large companies can be expanded to cover all employees.

The NPA advises pharmacists to either wait for developments, such as the possible introduction of its own scheme, or discuss their situation with an independent financial adviser.

Pharmacists may want to attend one of the seminars being run by pension providers, but the NPA urges them to be cautious. Only the larger pension providers, such as Standard Life and Prudential are likely to provide stakeholder pensions.

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3IBU44	IBUPROFEN 400MG OTC	48	1.27
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3IBUGEL3	IBUPROFEN GEL 30GM OTC	30GM	1.30
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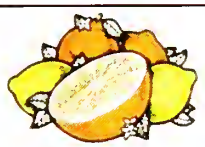

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Back issues

What's your poison?

Poisoning has, thankfully, declined with controls on the sale of poisons. But in 1900, *C&D* was carrying details of several cases each week of both accidental and intentional poisonings.

Carbolic acid was the major culprit, claiming a couple of victims each week, but other poisons included cyanide, benzoline, castor oil beans, ammonia, and potassium bichromate. Fatalities during February included:

- a doctor who mistook a potassium cyanide mixture for his daily dose of Eno's
- a lady who drunk ammonia from a wine bottle labelled "orange quinine-wine"
- a docker who ate castor oil beans that contained a "very poisonous ferment"
- a man who committed suicide on a train with prussic acid he had obtained "to destroy a dog".

Advertising was more fun in 1975, and pharmacists were not so concerned with health promotion

During a Royal Pharmaceutical Society Council meeting in 1950, in a discussion on whether to change the two year qualifying course to three years, a rather short-sighted president remarked that, "possibly it will never be a three year course".

In the **Comment** of a February issue the editor said that, with things as they were, "it would have been unwise to the point of foolishness" to set up the three year course at that time. Sound reasons were given: "The new syllabus is not yet ready, the teething troubles of the National Health Service have not lost their acuteness, and the shortage of pharmacists remains a grave problem."

A decision taken at the same meeting was the abandonment of the Society's herbarium competition, which had been running since 1857. The loss of this competition was lamented by **Xrayser**, who waxed lyrical on the joys of collecting one's own herbarium. He put the general lack of interest in botany down to the fact that "adolescents of the present day are for the most part interested in mechanical processes".

February 1975 saw an interview with officers of the Joint Boots Pharmacists' Association, who were having talks with four other large company chemist organisations in an effort to get a national employee pharmacists' association "off the ground". The officers included Paul Joyce, then assistant secretary of the Association, and a certain Roger Odd, then a co-opted member of the Council's general practice subcommittee nominated by the JBPA.

Mr Joyce had some rather outspoken views about the Society of the day. "My personal opinion is that the Society seems against company pharmacy and whenever there is an opportunity to change its structure they jump on the bandwagon. But it is too late for the Society to decide that it doesn't like the way pharmacy is practised in Great Britain; it must live with the fact that there are company chemists and employed pharmacists who like the way they practise and want to defend it." Could he say the same today?

Documentary to feature 24-hour pharmacy

The only pharmacy in the country that is open 24 hours a day, 365 days a year is to be the subject of an LWT television documentary.

Zafash Pharmacy on Old Brompton Road in London has been filmed in action on a Friday evening and into the early hours of the Saturday morning. The film crew arrived at 8.30am on the Friday and stayed until 3.45am on Saturday. They filmed staff in action, visiting doctors, customers, and interviewed customers and staff.

This is not the first time that Zafash 24-hour Pharmacy has been in the limelight. It has been on television and radio "on quite a few occasions". But Mohammad Khan, the pharmacy manager, believes that this is the first time a pharmacy has been the subject of a television documentary. The feature will be shown on 'Nightlife' some time in April, but the exact date has not yet been decided.

So who has been talking to who?

Who has been talking to Graham Searjeant of *The Times*? In a piece in last Thursday's business pages (February 10, **Analysis**, p35) he drifts far from his normal beat to talk about obscure things (to the national media, at least) like the "Whitehall review of the role of the pharmacist", which has been delayed and "is likely to be patronising and anodyne when it finally surfaces". Who told him that?

However, the thrust of his piece was about that old chestnut, healthcare spending. And his conclusions make interesting reading. There are ways to promote private spending that are additional and not a substitute for NHS spending, he suggests.

"A big advance could be made by deregulating primary healthcare and preventative medicine. A mutual monopoly in prescribing suits doctors and drug companies but not health consumers. Vested interests exploit the mystique of medicine so well that ordinary people are no longer allowed to buy a bottle of aspirin [presumably he means a large bottle of aspirin?], at enormous cost to themselves and the NHS.

"This attitude needs reversing. There should be a presumption that any drug passed for doctors to prescribe should be on general sale through pharmacies after two years unless a strong case is made to the contrary." Wow! Fighting talk indeed! Could this be a carefully leaked story from the policy unit at Number 10 to gauge public opinion to such a radical proposal?

Mr Searjeant continues: "Outdated licensing of pharmacies and limits on what they can prescribe undervalue the trained individual local chemist, and stop the big chains developing integrated High-Street healthcare centres. They should be able to open all hours to supply, prescribe and market preventative medicine."

Heady stuff! But that bit about licensing … more than a whiff of Superdrug about that.

Dial an impression with NHS Direct

NHS Direct, the scheme set up to make more efficient use of doctors' and nurses' skills, has had its nurses pretending to be answerphones asking callers to phone back later.

As the call centre for Surrey, Sussex and Kent became swamped with calls over the Christmas period, its automated answering system broke down. Rather than give worried patients an engaged tone, staff were told to repeat the official message in the comforting tones of a recorded message.

Callers were told to wait, call back later, or contact their GP. If the callers became suspicious of a stuttered message or background noise, staff were told to carry on regardless with their answerphone impersonation.

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hree weeks until No Smoking Day

Smoking Day is on March 8th,
millions of smokers will be
ing their pharmacy.
uitin CQ is currently the best selling
NRT patch, with half of all sales.[1]
So when smokers make the decision to
quit, they'll be thinking of NiQuitin CQ
as well as their pharmacist.

Together with NiQuitin CQ you can help
people make No Smoking Day a success.
After all, it's more than just one day.
It's the first day.

the
cancer
research
campaign

wever long a person has smoked, quitting is always a benefit"

NiQuitin CQ
Nicotine
STOP SMOKING AID

NiQuitin CQ, CQ and Committed Quitters are trade marks.
Reference: 1. IMS HEALTH Self Medication Pharmatrend™ w/e 8/1/00

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